NHSCA

EDITORIAL June 2012

Here we go again! Process rather than product. What a mess!

We in the NHSCA and all others who care deeply about the values and integrity of the NHS are profoundly frustrated, depressed and angry following the passage of the Health and Social Care Bill. We hope you will find this edition of the newsletter informative and provocative. We are delighted to include in this edition two articles on aspects of the bill which have received little attention. Lucy Reynolds from the London School of Hygiene and Tropical Medicine writes on the dangers of Personal health-care budgets and Sir Richard Thompson PRCP explains the huge problems posed by the bill to medical education and what he and his colleagues in the RCP are doing to mitigate some of the damaging proposed changes.

John Lister takes us through the maze that is now the so called (N) HS structure, so much for the reduction in bureaucracy! We include reflections by Eric Watts on the EGM of the RCPathology held on 21.4.12 and speech at this meeting by Jonathan Folb. We also include a piece by David Wrigley a GP from Carnforth in Lancashire and member of the BMA GP committee who describes some of the dangers to the doctor patient relationship which GPs will face in the new world. Our secret agent north of the border, Matthew Dunnigan, describes in detail how well the Scottish NHS is performing relative to its English counterpart without the shackles of the internal market. Perhaps we also need to know in future how the relative unit costs compare. Mark Aitken writes of his bruising experience as a governor of his local foundation Trust. If members have similar experiences we would be pleased to hear from them in a subsequent newsletter.

My co-guest editor vigorously attacks the Royal Colleges and BMA for not uniting to stop this bill. Probably the only time this might have been possible would have been right at the beginning of the process. This would surely have been the right course. Once the coalition were committed to it, in the face of the absolute intransigence shown by Andrew Lansley and his seemingly mesmerising hold over David Cameron, it would have been almost impossible to stop it, as we were told by Lord Robert Winston when we went to see him. The Royal College of Physicians then took the view that it was better to engage and try to amend by discussion rather than walk away and risk being totally ignored by government. This position was explained at an EGM on 27/2/12. Nevertheless, the overwhelming majority of those Fellows present at the EGM voted for rejection of the bill and this was reinforced in a subsequent ballot. This, of course, was all far too late. Whether the RCP pursued the right course or not, time will tell. However the RCP is at least still at the table and able to influence some policy as is shown by the changes made to the proposals on medical education under discussion.

Before the election David Cameron often repeated his lasting commitment to the NHS and promised 'no more top down re-organisation'. When the White Paper was published the NHSCA was probably the first organisation to actively campaign against what it contained. We were told these were evolutionary changes building on what the previous Labour government had started. However, Sir David Nicholson CEO of the NHS said 'the changes proposed were so massive they could be seen from outer space'. We were never told precisely the problem(s) the bill was trying to address. David Cameron in an article in the Sunday Times 'Its coming, the NHS you deserve' repeated his commitment to the NHS based on his personal experience. He outlined what he saw as the shortcomings, too much bureaucracy, decisions made by that bureaucracy instead of by clinicians. He repeated the often quoted information that the results of NHS treatment were inferior to that in other systems. He pointed to rising costs of

new treatments and to the need to contain costs. The Act fails to address these issues as countless articles by experts far better informed and eloquent than me have explained.

In relation to bureaucracy, instead of three layers of management there will be six new ones and a seventh if we include the health and well-being boards being set up in local authorities. Mr Cameron indicated that legislation was needed to abolish PCTs and SHAs, seen as the main areas of bureaucracy. However the replacement of 150 PCTs with over 200 clinical commissioning groups (CCGs) will result in the loss of the national element of the NHS to be replaced by a tangle of local services. These changes hardly amount to a reduction in bureaucracy but rather an increase. The loss of the SHAs will remove the mechanism whereby strategic planning can be undertaken. How will the re-configuration of services thought to be so necessary be achieved? Presumably, by market forces, the same mechanism which has left our country with the prospect of lights going out in a few years due to loss of generating capacity and ability to plan our national energy which will leave us at the mercy foreign energy providers such as Russia! We were told that it was essential to contain costs. It is highly unlikely that money will be saved as a result of the changes. The introduction of further market changes is likely to increase rather than decrease costs judging from the experience of USA. Increased choice and competition usually imply spare capacity which has to be paid for.

Another key aim was to promote more choice for patients. GPs who are responsible for commissioning will therefore have a conflict of interest when they recommend a treatment for their patients between what they recommend and what their commissioning budget will allow. Furthermore, if they are both commissioning services and providing this is a further recipe for conflict of interest. What is the patient to think? Putting GPs and nurses in charge rather than managers was another slogan used. Neither GPs nor nurses have been trained to do commissioning nor do the majority wish to do so. This of course will add further costs as they will need time away from their clinical duties to do this for which locums will have to found. Getting rid of thousands of well qualified managers has deprived the NHS of much needed experience and expertise.

David Cameron also indicated that outcomes in the NHS were inferior to those in other systems These figures have been disproved as has the myth of declining productivity [1].

These changes will do nothing to decrease the age of our population, the increasing incidence of dementia and the rising costs of treatments. The Commons Home Affairs Select Committee found no compelling evidence for the government's proposed changes to the judicial system. What a pity the Health Select committee nor MPs in general did not apply the same criteria for the health bill. It seems that most MPs blindly followed the party line without exercising any critical faculty as they have done over other measures. There is absolutely no compelling evidence that these changes were necessary or that they will achieve what the coalition has suggested .It is indeed truly remarkable that one man, Andrew Lansley, has been able to drive through this bill despite all the opposition from the majority of the professionals and the lack of any evidence that the changes would improve patient care.

Most who work within the NHS would agree that improvements are needed. The quality of primary care needs to be improved so that patients can get timely appointments, which allow sufficient time for a meaningful consultation and that patients do not have to resort to going to A&E. In hospital there has rightly been emphasis on improving emergency care. However for many physicians, the medical intake is now an ordeal. They are overwhelmed with sheer numbers of emergency admissions. Often the hard pressed consultants are the only doctors who are familiar with the patients. The rigid implementation of the European working time directive to 48 hours per week for junior doctors has, as predicted, resulted in the production of doctors who lack sufficient clinical experience, and to working of shifts resulting in multiple handovers of patients which adversely affect continuity of patient care. We need to restore sensible working hours for our junior doctors sufficient to allow them to acquire adequate experience and to provide continuity of care for their patients. There is a lack of general physicians who can manage and follow up patients with multiple problems which do not fall neatly into a specialty. This has prompted the Royal College of Physicians to launch a commission into the 'future hospital'

These are but some of the quality issues which need to be addressed rather than fiddling around with who does the commissioning, which is akin to rearranging the deck chairs on the Titanic! Why do successive governments think that altering the process is so much more important than improving the product? Why not ask the people who actually do the work?

Lord Crisp Chief Executive and Department of Health Permanent Secretary 2000-6 said in an interview on BBC's the World at One that the bill was a muddle and would set back the NHS. In a letter to the Times, he wrote 'we have a highly controversial bill, doctors and nurses up in arms and a public which is increasingly confused and concerned about the future. The NHS is too important for this confusion to continue. It is time for our political masters to lead. They must set aside party considerations - stop treating the NHS as a political football - and work together to create a cross-party political vision for the future of the NHS' Needless to say this did not happen nor is there any prospect of it happening. Despite demands for the bill to be scrapped made in the mountain of papers and volumes of speeches given by health experts, doctors and nurses, by the BMA and in the valiant 'Bevan' run from Cardiff to London by our co -chair Clive Peedell and even by commentators normally considered to be on the right such Camilla Cavendish and Rachel Sylvester in the Times and Mark Pemberton in the Telegraph, it was passed. Apparently the No10 strategists insisted that it was better for Mr Cameron to plough on with the bill rather than junk it. Abandoning the bill they argued would make him look weak in the face of criticism with a reputation for U-turns. It is sad that the government did not have the courage to change its mind in the face of all the evidence brought to its attention as it has done over the procurement of the new aircraft carrier fighter planes.

So we in the NHS are left with this ghastly mess. Professor Chris Ham (Chief executive of the King's Fund) who contributed to our December 2011 issue wrote in the BMJ 'the occupants of the remodelled NHS will wait anxiously to see whether those who constructed it were visionary architects capable of creating a lasting legacy or cowboy builders whose workmanship failed to match the promises made in their glossy brochures' [2] .We in the NHSCA know only too well which of these is correct!

(1) Black N. Declining health-care productivity in England : the making of myth Lancet 2012 3779 1167

(2) Ham C.What will the Health and Social Care Bill mean for the NHS in England? BMJ 2012 344 7

ROBERT ELKELES
Co-Guest Editor

EDITORIAL

"I'll huff and I'll puff - and I'll blow your house down"

This powerful line from a familiar nursery tale seems an appropriate opening to what I have to say about the bill and our profession's reaction to it, allowing me also to persist with my concerns about putting our own houses in order, expressed in previous articles.(Sept. and Dec.2011 Newsletters). But before I do, methinks I hear ghosts of certain political giants of the past giving their likely reactions had they been party to the debate----"lies, damned lies and statistics.----A lot of bluff, not much huff and hardly a puff" (Churchill) and " Well, what did you expect from those doctors, especially the BMA? ---and not much from those well-stuffed College mouths was there." (Bevan) And what should we, a tiny featherweight of an organisation which has done more than its fair share of leading the campaign and punching, as usual, well above our weight against the bill, make of it all? Not much I dare to suggest, and if you think I'm being unfair then by all means make your case after hearing mine.

As I recall it, our tiny pressure group, led quite ruthlessly by Clive Peedell, had to stimulate, nay provoke and shame our disorganised and disinterested apolitical Royal Colleges into belated action, with our members convening eleventh hour EGMs to challenge assumed presidential authority to represent the collective view of members and fellows over the Bill. In the process the grandly sounding Academy looked anything but grand or united as individual Colleges and their individual members interests began to surface.

Thus, the Royal Colleges representing Surgeons, Obstetricians and Anaesthetists displayed a deafening silence in response to presidential stances supporting the Bill whilst the other Colleges prepared the way for a belated democratic "vote"(more later about the "vote").

In selfless contrast Allyson Pollock and her dazzlingly professional group representing Public Health endlessly educated and cajoled Peers to challenge key lines of key amendments. And what was our darling BMA doing? It continued to display an all too familiar ambivalence, with spokesman Hamish Meldrum performing endless gymnastic twists and spin turns, surely sufficient to merit a "gong" in this Olympic year, especially having managed to stay upright on the tightrope despite repeated and hefty blows from our three doughty Council members.

No, I have not forgotten to mention Clare Gerada and her brave early personal impassioned challenge to the Bill but she and the RCGP holding a pivotal position in the eyes of the politicians and public eventually succumbed to the need for a "vote", and like the BMA formally representing the GP voice, a final concession emerged that it was necessary to enter into further talks with government if GPs were to work meaningfully with the Bill.

But let's look at the so called medical" vote". It was no such thing. At best it was a daring game of bluff, bought initially by the media and then by the public but not notably by the politicians such as Burstow, Lansley's sidekick. At worst it was a shoddy piece of belated amateur statistics unbefitting of our profession.

I am no statistician and I can appreciate that time was of the essence in conveying a message to politicians and the public, but electronic "spider" surveys or self-selecting open-access surveys are not polls and they cannot be construed as such, "and should never be presented as a representative survey", an opinion stated with no less an authority than youGov president Peter Kellner.

Allow me to quote selectively but fairly I hope from a lengthy RCGP Press office release of 11th January 2012 --"RCGP is a network of over 44,000 family doctors-----the largest body of GPs in the country and the largest medical Royal College. With nearly 2,600 completed responses, this latest poll of three surveys—conducted using online tool SurveyMonkey has attracted the largest (my emphasis) response yet". Clare Gerada concluded---"these results speak volumes about how our members feel about these reforms" Really!

Surely it's time to stop pretending to ourselves, to the politicians, to the media and not least to the public that we are a united body of professionals (97,000 in all according to Jacky Davis), totally committed to the NHS and it's founding principles and that we are prepared to fight for it to the death. We are not, never have been and will probably never ever be, whether we serve the NHS from a primary or from a secondary care base.(I believe the sum total of all the college "votes" against the bill was around 5,000).

General practice does not speak with one voice and the specialist Royal Colleges certainly do not. Indeed, it appears that most Royal Colleges are happy not to speak at all or to sully their hands over the dirty world of medical politics, judging from recent history.

So where do we go from here, with the BMA and the Royal Colleges hardly to be relied upon for "leadership", with whom do we engage over the future of the NHS and what are the realistic hopes and goals and how are they to be achieved? Difficult questions, some too early to answer and no doubt occupying future contributors to our Newsletter and issues surely for all of us to consider at our AGM in October.

There is no shortage of suggestions and promises in the immediate aftermath of the bill. Here are just a few:--

Ed Milliband has pledged that a Labour government would repeal the act "We will repeal the free market, free-for-all principles in this bill. That is an absolute commitment."

Clive Peedell is one of a group of doctors planning to form a single issue political party to defend the NHS and its founding principles with hopes to stand at least 50 NHS professionals as candidates in 2015, believing that there is a rising public appetite to vote for independents.

David Owen has offered to help develop specific amendments to return the NHS in England to an internal market without involving total repeal giving examples of keeping the NHSCB and Monitor but stripping them of powers to commercialise and marketise healthcare.

Clare Gerada has given her view of what the RCGP priority should be---"to focus on stabilising the NHS—addressing serious problems—namely, reducing budgets, increasing demand and increasing complexity of care ---having a national debate on what the NHS should provide, how it should be provided and how we deal with the big issues such as improving end-of-life care, supporting the increasing numbers of frail elderly living alone and reducing the health burdens created by alcohol, obesity and smoking ."

I go along with most of that and hope her colleagues do, too. Is the RCGP best equipped to co-ordinate the debate and who should be invited to contribute? Should politicians be invited or are they irrelevant having done enough damage recently in any case? And is the profession, including our own organisation, prepared to look closely at what an NHS of the future should provide and possibly not provide? We are back to the question I keep asking and which won't go away.

Jonathan Tomlinson, GP also takes a stance with which I can identify closely ---"one urgent need is for all of us to get involved with the new democratic structures, however toothless they may seem, ranging from patient participation in GP surgeries and GP commissioning groups, and membership of Healthwatch and health and wellbeing boards"

Jacky Davis stresses the need to keep track of the bill's effects "despite the difficulties in monitoring the changes as the service fragments and financial dealings and patient outcomes are lost behind a convenient curtain of commercial confidentiality". Typical Jacky precision!

In the same Red Pepper magazine/blog she argues that we need an urgent inquest into the abysmal failure of medical "leadership" and that early and united opposition would have seen off the bill long ago. I'm not sure about that argument. The most significant medical "leadership" in the whole campaign against the bill has been from Jacky and Clive and it has certainly not been "abysmal". Moreover, as I have attempted to argue, there was no prospect of early and united opposition.

If we are to have a debate about the politics of who represents the medical profession then we have to face the harsh reality that we are stuck with the BMA, hidebound by tradition, slow to change and realistically, having to represent the views and needs of different groups.

We have to look beyond this immediate bleak future, surely, to the next generation of future GPs and specialists emerging through our medical schools and ensure that their teachers are required to provide formal education, with testing, in the history and successful workings of the NHS. Are our medical schools up to the task and more importantly, do they realise why the question is being asked? There I go again, asking that same damned question about putting our houses in order. It must be time to sign off!

GEOFFREY MITCHELL
Guest Co-Editor

Education and Training White Paper

Now that the notorious Health and Social Care Bill has been enacted, attention is turning to the Department of Health's vandalic proposals to change the organisation of education and training of all health care staff. These seem to be predicated on the devolution of responsibility for the huge education and training budget to the new quango Health Education England, and then devolution of the money, control and planning of educational services to local boards (Local Education and Training Boards; LETBs), with the responsibility to provide these services belonging to providers or trusts.

Some of the initial loose proposals for postgraduate medical education in the 2011 White Paper Liberating the NHS: Developing the healthcare workforce (who thinks these up?) – and more than 90% of postgraduate education in the NHS is medical, rather than other professional groups – were thankfully amended during the debates in January and February of the Health and Social Care Bill in the House of Lords. Thus the new clinical commissioning groups will have to consider education and training when they commission services, commissioners will have to cooperate with the secretary of state's duty to regard education and training and any private or third sector providers of care to NHS patients will have to offer to be expected to take part in the provision of education and training of doctors. The postgraduate medical deans will remain and will have, as now, independent management of the quality of training of doctors, will rely on the Medical Royal Colleges to set standards and curricula for training, and on their members and fellows to carry it out, and on the GMC to regulate the training of doctors.

Thus far, better. However, the RCP continues to press for postgraduate medical deans always to sit on the LETB; to answer to the independent chairmen of the Boards and not, as was proposed, to a director of education and quality on the Board, who might not be a doctor; and to answer to Health Education England for national planning and for the coordination of the regional management of medical trainees. We further suggest that, if the director of education and quality for England on the Board of HEE is not medical, then there should be a director of medical education appointed who would be responsible for national postgraduate medical education.

We are in addition proposing that an undergraduate dean should sit on LETBs, and be responsible for all the undergraduate education and training of doctors and other professional groups. A close association between universities, the so-called academic health science networks, and the local training boards is envisaged.

The White Paper used the term multi-professional training. Although there are areas of overlap of training of all postgraduates across the health professions, we firmly believe that medical education and training are unique, because they are expensive, complex and arduous, and cannot be integrated with the education and training of other professions. Perhaps inter-professional would be a better description of those areas of fruitful overlap between the professional streams.

Finally, we believe that the proposal to plan the numbers and specialities of doctors in training locally so that providers can plan better for their future staffing needs is deeply flawed for medicine. They would help to provide a supply of locally trained nurses, for instance, but the large range of specialist skills and numbers in different medical specialities mean that a national, and not even a regional view, is needed for medical workforce planning; especially so for smaller specialities. The Centre for Workforce Planning is attempting to do this. There is evidence that many, but not all, medical trainees for understandable personal reasons prefer to stay within regions, but we believe that flexibility will give trainees the possibility to train in one region and then choose a suitable consultant post in another. This will help to prevent an incestuous, inward looking local

service, and encourages fertilisation of skills and ideas around the country. Otherwise this would surely be a return to fixing jobs as of old?

We are told that further plans, in the form of draft clauses, will be put forward in early summer, with the possibility of another legislative Bill on education and training later in the year. We are keeping our eye on all this and seeking further to influence these momentous changes.

Postgraduate Medical Training

I also want to inform members of the association of the views of the RCP on the quality of postgraduate medical training. I hear cries from both trainers (ie: consultants) and trainees that education and training are inadequate, right from medical school. Why is this?

Regarding medical schools, postgraduate trainers deplore the level of practical, mental and physical skills that medical students acquire at university. This raises the question of whether undergraduate education is fit for the core purpose of producing high quality young doctors? The RCP hopes that this whole area will be reviewed with the postgraduate Medical Royal Colleges. For instance, the Department of Health has been worried about the prescribing skills of foundation doctors, and so the medical schools are setting up a prescribing test, although this is not allowed to be a barrier to qualification. The RCP has introduced new categories of membership for medical students and for young doctors before they become full members, and these are already proving popular.

The reduction of legal working hours and the inflexibility of their application for trainee doctors enforced by the European Working Time Regulations and the New Deal have reduced the training opportunities for young doctors to gain proper clinical experience and develop the necessary skills. I am reminded that in any job 10,000 hours of practice are needed to obtain proficiency, be it in a profession, or music or sport. The practice of hospital medicine and surgery has changed, so that treatment is initiated more "at the front door", and length of stay has been reduced. These mean that the trainee loses the ability and responsibility to assess and initiate treatment on their own, instead referring early for a more senior opinion, and then cannot follow and learn about the course of a disease. The first has led in some acute medical units to consultants being up for the first encounter, and although I cannot deny the potential therapeutic benefit for this early and more effective senior management of seriously ill patients, it can push the trainee into someone who simply carries out orders and does not learn. A balance needs to be struck.

The average patient when they are admitted to a ward is increasingly old, frail and complex, and so the work of trainees there is busier and more difficult, particularly at night, exacerbated by the shortage of trainees due to the constrained working hours and lack of locums to fill gaps. The number of trainees is unlikely to increase. There is also currently a greater emphasis on quality and safety, which all of us as potential patients any day must welcome. But the downside of this is a lack of decision taking by trainees for a fear of being wrong, and referral on eventually up to the consultant.

Finally, the training consultants are busier than before, both because of the workload and increased complexity of care, and because they are pressed by local management to carry out more work for their trust by concentrating on reducing the money earning elective waiting lists.

What then are the solutions? First, I suggest that yet more consultants in the acute sector are needed, in spite of the large increase in their number over the last ten years. There will then be a better ratio of trainers to trainees, and more time for trainers to train. This will incidentally help to solve any bulge in the training numbers, but it will, of course, require more money! The UK health service is underfunded and under doctored among developed countries, and our patients deserve more trained doctors.

Secondly, training must be valued by hospital management, built adequately into consultant

job plans, and become more positive. Thus the RCP has urged its members and fellows "on take" to work into the evenings and over weekends to improve the quality of care, but this pattern of work can also allow more time for training the workforce and sometimes when it may not be so hectic and thus better suited to that training. Similarly, it is clear from talking to trainees that specialist nurses could be an increasing source of experience for young doctors to access. If physician assistants catch on in the UK then they are also a potential resource for continuity of care and for training.

Finally, we continue to urge the government, which is supportive, to renegotiate the constricting New Deal so that hours for training can be more flexible. Changes to the European rules are likely eventually to occur, but all staff can now easily opt-out individually from the European 48 hour rule; most consultants do so already. We remain disappointed that it is taking so long to improve the working lives of our young doctors and no wonder that so many are not keen to do acute medicine. Interestingly, the Royal College of General Practitioners is proposing that the training of post-foundation GP trainees should be extended from three to four years, simply to improve their product. Sadly, this for medical specialties, is unlikely to find favour!

The RCP continues to engage strongly on all these issues, which I know are of great concern to both consultants and trainees. Their professional life is not an easy one, and is likely to become even more pressurised.

Sir Richard Thompson KCVO, DM, FRCP
President, Royal College of Physicians

Personal health CARE budgets as a transition state to profit-driven care

When the idea of introducing Personal Health Budgets (PHBs) in this country was first voiced, the Director of the King's Fund warned that the concept conflicts with a fundamental NHS principle, equity of care[1]. Sixty-eight pilots were nevertheless set up. Now the roll-out of PHBs for everyone from late 2012 has been announced[2].

The introductory-phase budgets are generous, and more choice for patients has been welcomed. As PHBs outsource administration of care to patients themselves, they benefit more-independent patients and dependent patients with trustworthy, motivated, and competent carers. However, as Van Ginneken and McKee document in a recent BMJ article, Dutch PHBs have diverted public funds to ineffective therapies, consumer spending, and unscrupulous brokers[3].

Substantial fraud and abuse emerged in the now-discontinued Dutch PHB experiment[3]. Early evaluations of English pilots reported that budgets failed to cover the previous level of service for some patients, and NHS teams no longer resolved problems with suppliers[4] . The DH predicted problems with PHBs, including exclusion of hard-to-reach groups, widening of inequalities, safeguarding issues, and public resistance to the rationing of access to healthcare involved and the fact that budgets will be too low to fund best practice interventions[5]. They also noted lack of transparency and means to measure outcomes. Furthermore, the switch to individual patient accounts destroys the national system of universal risk pooling and exposes each of us to financial risk from ill-health if the PHB turns out to be finite, as "budgets" tend to.

Will news of the drawbacks of PHBs convince UK policy-makers to drop their roll-out? Perhaps not: PHBs fit within a transition to an insurance-based model of care provision, part of a wider

NHS marketisation plan[6]. The DH report[7] recommending PHB pilots discussed their role in increasing competition within health services, postulating three options:

1. *Notional personal health budget - patients made aware of the options available within the budget constraint. The NHS retains all contracting and service coordination functions.*

2. *Personal health budget held by an intermediary on the patient's behalf.*

3. *Healthcare direct payment with which to purchase and to manage services. New legislation would be required for this model, which will only be appropriate for some.*

When our leaders guarantee NHS care "continuing to be free at the point of need" we hear "nothing's changing". But this "guarantee" equally fits an NHS-funded/private health insurance-based system, centred on option 2 above. As explained to potential investors by a former DH Commissioning Director:

"In future, the NHS will be a state insurance provider, not a state deliverer[8].

PHBs are transferable government subsidies from the NHS budget to the private healthcare and health insurance industries. CCGs are being set up at public expense with the PHB-centred administration systems needed for compatibility with such transfers. Have you noticed the current abundance of advertisements for top-up private health insurance? If patients allocate their PHBs to their insurance companies not to CCGs, a two-tier service in English hospitals will result.

In 2004 Oliver Letwin reportedly told constituents that *"the NHS will not exist any more"* within five years of a Conservative victory, but would be just a *"funding stream handing out money to pay people where they want to go for their healthcare"*[9].

This final top-down NHS reform, or dissolution, would deliver a state-subsidised US–style insurance-based private healthcare market. The DH has targets to maximise the proportion of non-public sector providers commissioned[10]. Soon all the NHS hospitals will have exited Monitor's pipeline into the private sector. Thereafter "NHS" will be just a branding for "Any Qualified Providers", all of whom will be privately owned.

We will have a plethora of "choices" of service provision packages to research when purchasing service access from among struggling NHS-only local CCGs and booming nationally-based insurance companies. Healthy young men will be showered with bargain top-up insurance offers seeking to attract their PHBs. Cover may be denied to people with "pre-existing conditions", diseases manifested before the last premium was paid, leaving them exposed to medical bills alongside the uninsured.

A luxury service will offer high-tech medicine for private patients, including more medical tourists, as our Prime Minister seeks "to drive the NHS to be a great business"[11]. Prices will rise, and so will overtreatment. Our US-derived diagnosis-based tariff system ("Health-Related Groups") promotes overcharging, over-investigation and over-treatment mediated through supplier-induced demand and data manipulation. Coding patients for more aggressive treatment than they need makes the outcome statistics look good, triggers bonuses, and makes money for the hospital[12] but also increases morbidity and mortality: no treatment is devoid of risks. In meta-analyses of US healthcare statistics, costs were 19% higher[13] and death rates 2% higher[14] in for-profit compared to not-for-profit hospitals.

There will be second rate and patchy provision for the rest of us. Where PHBs must be overspent for needed care, in future the patient rather than the government can be charged. Spending of PHBs on ineffective therapies may at once waste the funds needed for acute care and raise the risk of its necessity, increasing mortality. The proportion of satisfied users will shrink rapidly unless PHBs rise proportionally with cost increases in medical provision; this does not seem a realistic scenario.

This "modernisation"[13] threatens to roll English health provision back seven decades.

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and Tropical Medicine

NHS: a guide through the wreckage

Andrew Lansley's Health & Social Care Act, which eventually passed through parliament in March despite massive and growing opposition – not just from health unions and campaigners, or the wider public, but also from GPs and from hospital doctors.

It's set to change the landscape of the NHS. The changes are not instant, but will be imposed at a forced march, with most to be implemented within a year.

It will sweep away the 150 or so Primary Care Trusts that currently hold the budgets to commission services for defined population areas, and also carry out over 120 Statutory Duties, many of which involve protecting patients' rights, protecting the vulnerable and properly accounting for hundreds of millions of pounds of public money.

Also disappearing are Strategic Health Authorities, whose role included coordinating PCTs, overseeing NHS Trusts, and organising the education of medical and professional staff.

Neither set of bodies was especially popular with the public or a model of democracy, although PCTs and SHAs are at least obliged to meet in public and publish their board papers: they have been the main vehicle for unpopular government policies, and recently for driving through spending cuts and imposing cutbacks and closures on local hospitals. But they currently plan and control budgets of around £80 billion, and are set to be wound up by April 1 next year.

Their replacement will be far worse: a new and even more complex many layered bureaucracy, including:

A new National Commissioning Board

This will have 3,500 staff, nine national directorates and "a national network of local offices", and will initially work through 52 transitional "clusters" of PCTs to oversee the establishment of Clinical Commissioning Groups (CCGs) (see below).

The NCB will be the body that commissions primary care services, specialist health services, and oversees CCGs, with extensive powers to select their leaders, intervene and to decide whether or not to agree CCG proposals.

237 Clinical Commissioning Groups

These will be the local level commissioners, composed largely of GPs, with a token involvement of a hospital consultant and a nurse from outside the area, and in many cases management roles taken by non-GPs. CCGs need to seek authorisation from the NCB, which will be considered in "waves" from autumn 2012 through to January 2013.

Up to 40 Commissioning Support Organisations

CCGs will be advised, and in many cases much of their commissioning work would be shaped, by up to 40 Commissioning Support Organisations, initially to be hosted by the National Commissioning Board, but no later than 2016 these will be hived off as commercial concerns, selling their services to CCGs. These have to present business plans in August 2012 and seek authorisation, with decisions announced in October.

Referral Management Centres

GPs' clinical decisions on which patients to refer where, and for what treatment will also be second-guessed by a growing network of "referral management" organisations, some operated by the private sector, which already cover at least one in four GP practices.

15 'Clinical Senates'

The composition, role and purpose of these has still not really been explained except as a sop to placate marginalised hospital consultants for their exclusion from any role in commissioning.

108 NHS Trusts

Those that have not been able to make the transition to Foundation Trusts are now on a forced march towards Foundation status – or face the threat of dismemberment and mergers by 2014.

For many of them the process will be painful, because the stumbling block to FT status is their parlous state of finances – in many cases centred on the massive cost of PFI hospitals.

143 Foundation Trusts

These were originally the high-flying, financially strongest Trusts, but the cash squeeze has meant

that a growing number are struggling to balance the books.

Any Qualified Provider

Between them, Monitor and the CQC will be charged with drawing up a register of organisations deemed "qualified" to be licensed to deliver health care in England: GPs will be required to offer patients the option of "any qualified provider" in an increasing range of services, beginning with three locally-chosen community and mental health services from September this year.

Up to 152 Health & Wellbeing Boards

These are to be run by local councils. 138 are already operational, although the form is likely to vary widely from one council to the next.

In theory, according to the Department of Health "Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way.

As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future."

In practice, HWBs can be composed of as few as six people, only one of whom may be an elected councillor, and their actual powers, which come in from April 2013, will be limited, especially where the political leadership of the council clashes with the leadership of its local CCG(s).

Council Health Oversight and Scrutiny Committees

Still running, although of varying effectiveness, these survive the new Act: composed of elected councillors, who have the power to co-opt, they will continue to offer a forum to which health and social care managers and services can potentially be held to account, but in sadly few HOSCs are these powers used effectively.

Public Health England

This new special health authority is to be set up to oversee the transfer of public health functions (and the staff with the knowledge on planning services for whole populations) from PCTs to local councils. There will be an allocation to councils of allegedly 'ringfenced' funding from April 2013 for public health services – while every other council service is facing a massive and continuing squeeze in the drive for 28% cuts.

Monitor

The body that regulates Foundation Trusts is to have new powers. It is required first and foremost to "exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services." So despite a formal requirement not to discriminate between public and private provision, its task is to ensure maximum private sector challenge to existing NHS providers.

But the Act also says that where it chooses to do so, it is also free to decide whether or not to "exercise its functions with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way". Nobody really expects this to happen: it was one of the LibDems' token, toothless amendments.

Cooperation & Competition Panel

This grim relic of New Labour's eagerness to turn the NHS increasingly into a competitive market lingers on under the chairmanship of fanatical privatiser Lord Carter of Coles. It will continue to act as a complaints panel for aggrieved private sector companies demanding the right to a slice of NHS budgets in profitable services, and will serve as an advisory panel to Monitor.

Care Quality Commission

This was formed in 2009 from the merger of three previous regulators and is supposed to regulate the quality and safety of over 21,000 care providers , but according to the Commons Public Accounts Committee it has "failed to fulfil this role effectively". The PAC declared it has serious concerns about the CQC's "governance, leadership and culture".

Its effectiveness is certainly questionable. Later this year the CQC is required to register 10,000 GP practices – by asking GPs themselves to declare whether or not they are meeting the essential standards.

The CQC chair Dame Jo Williams recently complained that it had been obliged to abandon 580 planned inspections in order to comply with Andrew Lansley's instruction to conduct a spot check on 250 abortion clinics (at a cost of over £1 million) – indicating how little independence the CQC actually has from government.

The CQC has admitted an "unforgivable error of judgment" in failing to act on a whistle-blower's "grave" concerns about the behaviour of staff at Winterbourne View care home, later exposed in footage shown on Panorama.

The PAC points out that while whistleblowers have to be a key source of intelligence in helping the CQC to monitor the quality of care, it has closed its dedicated whistleblowing hotline.

In March, Celia Bower, the CQC chief executive resigned after a Department of Health report said the CQC had faced "operational and strategic difficulties" with delays having "seriously challenged public confidence in its role".

Baroness Young, its previous chairman, resigned after Basildon Hospital, in Essex, was exposed for having filthy wards and a high death rate despite being rated as "good" a month previously.

Healthwatch England

This new quango, is to be a subordinate "independent" part of the Care Quality Commission, to be followed by local Healthwatch groups.

Healthwatch is the latest, even more toothless incarnation of a "patients' voice" and follows a growing list of inadequate and marginalised bodies set up after Labour scrapped Community Health Councils and stripped away their extensive statutory powers.

Exploit the few loopholes in the Act

Foundation Trust members and Governors

Foundation Trusts are obliged to have members and a board of governors. To be a member, you have to be over 16 and live in the catchment area of the FT. The trust will define what "catchment" means.

As a member you will be able to speak at members' meetings and attend trust board meetings – which means that you'll be able to ask the board questions. Members can also stand to be governors: the governors have to approve the trust strategy and appoint the auditors. They also appoint non-executive directors (NEDs, including the Chair of the trust) who sit on the trust board.

The government says that before an FT can increase its private patient income to over 5% it has to have the approval of the Council of Governors.

Governors should also monitor all of the trust's finances carefully.

Health and Wellbeing Boards

Councillors (district, county or unitary) can stand to be a member of the local Health and Wellbeing Board, which will be able to challenge local commissioners (CCGs) on their commissioning decisions, including those that involve transferring NHS services to private companies.

HWBs also have discretion to widen their participation: campaigners should press their local councils to make them big, vocal and active.

HealthWatch

HealthWatch will be local organisations with a mandate to inspect their health and social care services. Local HealthWatch will be hosted by local councils and are intended to be largely toothless.

However, HW will put together reports on local services, which can be escalated to the national HealthWatch and CQC (Care Quality Commission). A HW member will also sit on the local HWB and can challenge commissioning decisions.

HW will also have a mandate to inspect all providers.

Patient involvement

The Act says that there has to be patient involvement in commissioning. Your local GP will have a patient participation group (if not, then it will have very soon).

The actual commissioning decisions will be carried out by the CCG, but you may find that the GP group will give you access to the CCG patient involvement group.

CCGs have to have a policy on patient involvement. Ask your local CCG what patient consultation they are carrying out, and ask to be involved.

If you are involved in the formulation of the CCG policy and the CCG decides to use the private sector you could make this public and spark a local debate.

John Lister

A College under challenge to change

Report from the EGM of the Royal College of Pathologists 21/4/12

Archie Prentice, College President explained the statute and ordinances of the College responsible for the time taken to respond to the call for an EGM and stated that the business of the College is conducted by the Council who would consider the result. He regretted the delay, that the rules would be reviewed as we could not respond fast enough to political 'lightning strikes', such as this Bill.

Jonathon Folb reminded us that there was no electoral mandate for the Bill, stated that profit would replace public service and that there had been a failure of the democratic process.

I presented my concerns in making radical changes to an NHS which performs well in comparison with health care in other countries* and my concern of the effect of increased private provision. As professionals we should and I believe (mostly) are striving for continuous improvement and we are making real progress. Pathology in particular is going through such a major upheaval, post Carter, that we need some time to allow new structures to take place before we can evaluate the need for further change.

Much has been written of the strengths and weaknesses of the NHS and I believe that a major strength comes through cooperation in providing a comprehensive service with shared values which could be undermined by fragmentation. We should also look at the record of private providers, which shows that although they have more ready access to capital, they do not always use it well. Relevant examples being that ISTCs were shown to cost 12% more than NHS equivalents and that Southern Cross a major private provider of nursing and care homes collapsed as a result of changing market forces and poor management.

We live in uncertain times, one old cliché is the best way to predict the future is to take charge and make it happen - so the best opportunity for us to influence the future will be to advise commissioners on how to obtain a good pathology service and to warn of potential dangers of competing on price alone.

Rachael Liebermann, College Registrar, explained the electoral mandate for College Council and College's position of critical engagement. She explained that there had been much discussion of the Bill at Council and the members had shown strongly held views in line with those of the wider Fellowship who were passionate in debate. Archie spoke again after the vote, which was carried out by hand-held key pads. Archie explained the benefits of behind the scenes diplomacy, he had been in conversation with medical peers Lords David Owen, Leslie Turnberg (a former President of RCP London) and Nigel Crisp, (ex CEO of the NHS). Having considered an offer to write for the Times on the subject, but with conditions attached, he had decided to avoid public statements as the media were more interested in a good story rather than a considered and balanced opinion.

The fruits of this labour have been the opportunity to see and make recommendations for amendment of the DoH Pathology Commissioning Toolkit and leading other members of the Academy of Royal Colleges on providing guidance for commissioning through RCPath Consulting.

Eric Watts

Address to the RCPath EGM

I would like first of all to thank the College for honouring its obligation to its members in convening this Extraordinary General Meeting, and also to express my appreciation for the positive and constructive efforts which I know it has made to improve the Health and Social Care Bill during its passage through parliament.

With 25 other Fellows of the College, I requested that this meeting be convened because of my conviction that the Health Bill was so misguided, and so obviously damaging in its likely consequences, that our moral and professional obligation to oppose it should outweigh any other consideration.

I believe that the effect of this legislation will be to undermine the most important principles upon which the NHS was founded – principles of fairness and equality, of universal access to comprehensive care regardless of ability to pay, and of clinical decision-making that is not influenced by financial gain.

Instead of a universal and publically accountable service funded through taxation, we will be left with a fragmented, inequitable and unstable system, whose focus will be services and low-risk work that are financially profitable. Profit will replace public service as its guiding principle.

The Bill lacked any mandate from the electorate; it was published unexpectedly without prior consultation, and contrary to assurances that no major reorganisation of the health service was intended. This is not only my view; it was also the damning assessment of the Information Tribunal in its ruling on the government's refusal to publish its Risk Register. The public were repeatedly misled by claims that what was happening did not represent privatisation, and that the Bill enjoyed the support of the medical profession. And the assertions that its effect would be to improve efficiency and value for money fly in the face of all the available evidence.

The medical profession engaged with the consultation process constructively and in good faith. But it became clear over time that none of the very many increasingly confusing amendments made to it, was intended to address the Bill's most fundamentally damaging aspects.

Despite all these amendments, the Bill in its final form still:

- promoted competition between healthcare providers, which will in practice often be based on cost rather than quality, and which will be at the expense of collaboration
- set the legal basis for the provision of fewer services, created confusion as to where responsibility will lie for commissioning certain services, and legalised the exclusion of people from health services
- legalised the introduction of charges for some services which previously have been free
- allowed commercial interests a role in determining the appropriateness of certain services
- did NOT legislate against "cherry-picking" by providers of healthcare services, but merely required them to be transparent about their patient selection criteria. It is not yet clear how patient eligibility or selection criteria may be determined.

Every survey of grassroots medical opinion, and every College EGM, confirmed the alarm and opposition of a large majority of doctors who expressed a view. This could and should have been translated into a more determined effort to seek the Bill's withdrawal.

The passage of the Health and Social Care Bill into law represents a failure of the democratic process, and of the medical profession to defend the public from unnecessary and misguided political interference.

With the passage of the HSCB into law, the motion submitted for debate is now irrelevant, and I cannot therefore ask you to support it. That is not to say that our role in opposing the injustices that it heralds, is at an end. The challenges facing us all now, are enormous. In meeting them we must be faithful to the principles of fairness, equality and public accountability.

Jonathan Folb

Nursery Rhyme Corner

Hey diddle diddle

Hey diddle diddle the vote was a fiddle
The debate was over too soon.
Cleggy just laughed to see such a farce
And the Con-Dems were over the moon

Three Blind Mice

Tory blind mice, riding on their bikes
Such unsteady wobblers- like all that Lib-Dem cobblers
About a threat to fight just disappearing out of sight
And Cleggy with the nerve
To claim "We made them swerve"!

Geoffrey Mitchell

Quality - at what cost?

We have heard much about the Health Act and how it will lead to increased competition within the NHS (and therefore increased cost) and also open up the NHS to private providers in a big way, meaning the lawyers and accountants will have a field day making money from negotiating market-driven NHS contracts.

The Future Forum worked on the Health Bill during the most unnatural pause of the legislation and didn't make many significant changes to it. The beating heart of the Health Bill – the increased and vastly expanded role of the market in healthcare – remained healthy and strong.

But something else very sinister remains at the centre of the Act. Something that could seriously undermine, or even destroy, the doctor patient relationship. It is called the 'quality premium'.

This concept is all around paying clinical commissioning groups (CCGs) a 'bonus' if they find themselves with a surplus on their budget at year end and they have met certain 'targets'. In fact here is the exact DH quote on what the quality premium will be for:

'We will ensure that commissioning groups receive a quality premium only where they can demonstrate good performance in terms of quality of patient care and reduced inequalities in healthcare outcomes.'

Now that sounds OK if you read it in isolation. A little like Quality Outcome Framework Payments (QOF) in primary care maybe – good quality care leading to better patient outcomes and hence increased resources. But remember this payment is in the context of commissioning.

Commissioning is all about remaining within budget and having the right contract for the right provider at the best possible price to the NHS. So the quality premium will be paid out to CCGs if they perform well. This means if they come in budget.

Lets be blunt about it - everything in the NHS at the moment is focussed on being 'in budget'. We see the most draconian of cuts before us with the NHS being asked to slash £20bn from its budget over the next few years. This is unprecedented and has never been successfully done in any other leading health economy before. We are talking about cutting one fifth of the NHS budget – an enormous sum of money.

So let us take this quality premium down to the consulting room and what might happen there. All GPs now know that money is tight in the NHS. Patients know this too but they still trust their doctor implicitly to do the best thing for them and make the right decision for them. Doctors remain year on year the most trusted profession in the country – with politicians and journalists the least trusted profession in the UK!

But if we have this quality premium in place then the way patients see us will change. We may well decide for good clinical reasons that a course of treatment or a procedure is not appropriate for our patient sat in front of us. However, there will be a niggling thought in the back of the mind of our patient of: 'Is my GP saying this for good reasons, or because he wants to ensure there is some money left at the end of the year to distribute amongst himself and his pals?'

This is a serious concern and could have far reaching implications for the very trusting relationship we have with our patients and on which the whole basis of our consultation is built upon. We would see ourselves knocked off the top slot in the ranks of 'trusted professions' - much like in the USA where doctors are less trusted because they have a financial incentive to investigate and treat patients.

We cannot allow this to happen in our NHS and to our doctors. This quality premium must not be allowed to come about in this way. it is vital for our patients and vital for our profession that we fight this dreadful concept.

David Wrigley is a GP
in Carnforth, Lancashire and
member of the BMA GP committee.

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Competition .v. Cooperation: the performance of the English and Scottish NHS since devolution

In my contribution to the June 2011 newsletter, I described marked differences in post-devolution trends in clinical activity between the Scottish and English secondary care sectors. The present updated report examines these in more detail and clarifies similarities and differences between a publicly financed health economy based on competition between providers and a traditional public sector health economy characterised by cooperation in the absence of perverse financial incentives to increase provider caseload and income.

Scottish NHS Performance

As noted previously, the performance of the Scottish and English secondary care sectors prior to devolution was similar. Between 1985-86 and 1998-99 inpatient and day case hospitalisation rates rose by 47% (episodes) in Scotland and 41% (FCE's) in England. New outpatient rates in Scotland and England rose by 24% and 30% respectively and new A&E rates by 29% and 17% respectively.

In contrast, in the twelve year period following devolution (1998-99 to 2010-11), Scottish inpatient and day case hospitalisation rates did not rise; in 2010-11, they were 2% below 1998-99 levels. New outpatient rates rose by only 4% over this period (0.3% p.a.) and new A&E rates by 13% (1.1% p.a.). Consultation rates in general practice between 1998-99 and 2009-10 remained stable, rising by only 1% over eleven years.

This change suggests that in post-devolution Scotland, demand for secondary healthcare either stopped rising spontaneously and/or was constrained by Scottish Government Health Department policy. Between 2003-04 and 2010-11 an equilibrium was also established between supply and demand, indicated by falling waiting lists and waiting times for inpatients, day cases and outpatients, falling waiting times in A&E departments and reductions in delayed acute discharges. Stable consultation rates in the primary care sector were consistent with constant levels of community morbidity as noted above. Over this period, the Scottish government abandoned the internal market, the privatisation of clinical services and resort to the private sector for NHS patients. Health policy remained based on cooperation between purchasers and providers rather than competition, and a needs-based funding formula was retained. Policies such as Restoring the Balance sought to contain demand for acute and long-term healthcare within the primary and community care sectors.

English NHS Performance

In contrast to Scotland, English inpatient and day case hospitalisation rates rose by 27% (2.3% p.a.) between 1998-99 and 2010-11, new outpatient referrals rose by 69% (5.8% p.a.) and new A&E attendances by 52% (4.3% p.a.). In 2010-11, inpatient and day case rates in England were 12% above Scottish levels, new outpatient rates were 45% higher and new A&E attendance rates were 30% higher. Nevertheless, Scottish national morbidity and mortality rates remained higher than in England (in 2008 age-Standardised Mortality Rates were 22% higher). This paradox was partially resolved by further analysis of the data.

In 2008-09, estimated GP consultation rates in England and Scotland were 3.4 and 3.2 per person year respectively. In 2010-11 emergency admission rates were identical (101 per 1000 population in both countries). In contrast, elective inpatient rates in England were 18% higher than in Scotland (78 .v. 66 per 1000 population) and day case rates were 21% higher (109 .v. 90 per 1000 population). The close similarity of English and Scottish rates for both severe acute illness (emergency admissions), primary care consultations suggests

that the surge in English hospitalisation rates for day cases, outpatients and A&E attendances between 2003-04 and 2010-11 may have resulted from factors other than rising unmet need.

Perverse Financial Incentives in the English NHS

Mechanisms driving up secondary care caseload were created by changes in organisation within the English NHS initiated by the 2002 NHS Plan. These expanded the concept of a competitive healthcare market with increasing emphasis on "choice", the establishment of financially independent foundation hospitals, an increasingly competitive role for the private sector in providing NHS funded secondary care and the introduction of Payment by Results in 2003-04 (PBR). The latter funding mechanism, fully introduced to all NHS Hospital and Foundation Trusts by 2006, provided powerful perverse incentives to increase inpatient, day case and outpatient caseload from which up to 60% of an English NHS hospital's revenue is now derived.

A new GP primary care contract was introduced in 2002. This removed the need for GP practices to provide 24 hour cover and devolved this function to independent GP cooperatives and private sector deputising services. Difficulty in obtaining out of hours advice and lack of confidence in telephone advice delivered by nursing staff appeared to contribute to a rapid rise in self-referral to A&E departments in England, and to a lesser extent in Scotland (see above) where out of hours cover is entirely provided in the public sector by NHS Scotland (NHS 24).

Office of National Statistics (ONS) Study of NHS Waiting Times and Elective Admissions (Tables 1-5)

In 2010, the Office of National Statistics published a study of waiting times and numbers of hospital admissions for eleven selected elective procedures performed in the UK's four NHS health economies between 2005-06 and 2009-10. NHS Information Analysts from each country cooperated in the organisation of this study.

Assessed by annual rank order for each procedure, Scotland had the lowest 50th percentile waiting times for three of the five years studied and England for two years (Table 1).

Table 1

Rank order for 50th percentile days waited for 11 elective procedures in the English, Scottish, Welsh and Northern Irish NHS between 2005-06 and 2009-10[1,2]

Year	England	Scotland	Wales	Northern Ireland
2005-06	1st (20)[1.]	2nd (21)[1.]	4th (38)[1.]	3rd (31)[1.]
2006-07	2nd (21)	1st (17)	4th (37)	3rd (33)
2007-08	2nd (20)	1st (16)	4th (41)	3rd (32)
2008-09	1st (16)	2nd (18)	4th (38)	3rd (37)
2009-10	2nd (20)	1st (17)	4th (42)	3rd (40)

1. Annual sum of 1st to 4th rankings for 11 procedures (Range: 11-44)
2. UK Health Statistics 2010 (ONS)

Northern Ireland and Wales ranked third and fourth respectively. For 90th percentile waiting times, England ranked first or first equal for four of five years and Scotland ranked first equal for three years (Table 2).

Table 2

Rank order for 90th percentile days waited for 11 elective procedures in the English, Scottish, Welsh and Northern Irish NHS between 2005-06 and 2009-10[1,2]

Year	England	Scotland	Wales	Northern Ireland
2005-06	1st (16)[1.]	2nd (19)[1.]	3rd (34)[1.]	4th (40)[1.]
2006-07	1st (17)	2nd (18)	4th (38)	3rd (37)
2007-08	2nd (18)	1st (15)	4th (41)	3rd (35)
2008-09	1st= (17)	1st= (17)	4th (41)	3rd (33)
2009-10	1st= (16)	1st= (16)	4th (40)	3rd (37)

1. Annual sum of 1st to 4th rankings for 11 procedures (Range: 11-44)
2. UK Health Statistics 2010 (ONS)

Northern Ireland and Wales again ranked third and fourth respectively. Between 2005-06 and 2009-10 England's average reduction in 50th percentile waits for eleven procedures was 40% and Scotland's 41% (Table 3);

Table 3

Time waited (days) for 11 elective procedures in the Scottish and English NHS between 2005-06 & 2009-10[1,2]

Procedure	Scotland			England		
	2005-06	2009-10	Change %[2]	2005-06	2009-10	Change %[2]
	50th percentile			50th percentile		
1. Angioplasty	41	23	-44%	56	34	-39%
2. Angiography	35	20	-43%	65	28	-57%
3. Bypass Surgery	47	37	-21%	65	45	-31%
4. Cataract Surgery	97	56	-42%	69	57	-17%
5. Hip Replacement	156	78	-50%	161	81	-50%
6. Knee Replacement	165	81	-51%	169	82	-51%
7. Bladder Endoscopy	48	26	-46%	36	21	-42%
8. Upper G.I. Endoscopy	35	27	-23%	29	21	-28%
9. Hernia Repair	92	61	-34%	99	57	-42%
10. T & A Removal	93	54	-42%	102	58	43%
11. Varicose Surgery	141	65	-54%	133	62	-39%
	Average Change: -41%			Average Change: -40%		

1. 2009-10/2005-06%-100
2. UK Health Statistics 2010 (ONS)

90th percentile waits for Scotland and England each fell by 43% (Table 4).

Table 4

Time waited for 11 elective procedures in the Scottish and English NHS between 2005-06 & 2009-10[1,2]

Procedure	Scotland			England		
	2005-06	2009-10	Change %[2]	2005-06	2009-10	Change %[2]
	90th percentile			90th percentile		
1. Angioplasty	105	55	-48%	91	72	-21%
2. Angiography	57	38	-33%	163	55	-66%
3. Bypass Surgery	124	75	-40	110	96	-13%
4. Cataract Surgery	190	112	-41	112	113	+1%
5. Hip Replacement	286	144	-50	272	144	-47%
6. Knee Replacement	310	152	-51	287	148	-48%
7. Bladder Endoscopy	183	71	-61	140	56	-60%
8. Upper G.I. Endoscopy	117	52	-56	109	43	-61%
9. Hernia Repair	204	119	-42	219	117	-46%
10. T & A Removal	198	103	-48	211	124	-59%
11. Varicose Surgery	332	147	-56	266	129	-52%
	Average Change: -43%			Average Change: -43%		

1. 2009-10/2005-06%-100
2. UK Health Statistics 2010 (ONS)

Reduction in waiting times achieved by Scotland and England between 2005-06 and 2009-10 were thus virtually identical, with Northern Ireland and Wales lagging.

The availability of total numbers of completed procedures also permitted the calculation of yearly hospitalisation rates per 1000 population for the group of nine elective surgical procedures and the group of two endoscopic procedures (Table 5).

Table 5

Hospitalisation rates for eleven elective procedures in the English, Scottish, Welsh and Northern Irish (N.I.) NHS between 2005-06 and 2009-10[1]

Country	Hospitalisation Rate per 1000 population Elective Surgical Procedures (n=9)				
	2005-06	2006-07	2007-08	2008-09	2009-10
England	12.5	12.3	12.9	12.8	13.3
Scotland	13.3	13.5	13.2	13.1	13.3
Wales	13.0	13.9	14.3	14.7	13.4
N.I.	13.4	13.8	14.8	13.7	12.6
Country	**Elective Endoscopic Procedures (n=2)**				
	2005-06	2006-07	2007-08	2008-09	2009-10
England	6.7	7.6	8.5	8.4	10.3
Scotland	9.1	9.1	9.1	8.9	8.7
Wales	11.3	11.7	11.3	12.1	11.6
N.I.	13.4	13.7	13.9	15.1	12.9

1. UK Health Statistics 2010 (ONS)

For nine surgical procedures, average hospitalisation rates for each of the four countries showed no time trend over five years. Differences among countries were very small (less than two per 1000 population for each year examined). All elective surgical procedures were carried out as inpatients or day cases. The similarity of hospitalisation rates over time and among the four health economies for this range of precisely defined major and minor surgical procedures clearly reflects similar selection criteria by the surgeons involved. It is also noteworthy and gratifying that perverse incentives to increase hospital caseloads in England had no discernible effect on English hospitalisation rates for these procedures. The underlying stability and similarity of elective surgical hospitalisation rates among the four UK health economies supports the hypothesis that the rapid rise in English day case and outpatient hospitalisation rates between 2003-04 and 2010-11 was greatly amplified by PBR-driven incentives in a competitive market-driven health economy.

There was greater variation over time for each country's hospitalisation rates for endoscopic procedures, but no obvious time trend other than in England (Table 5). Among country hospitalisation rates varied considerably; differences between the highest and lowest rates exceeded 60% for four of the five years examined. This wider variation in endoscopic hospitalisation rates seems likely to reflect the relative proportions performed as day case or outpatient procedures in a given year. In England, the King's Fund Reading List notes several examples of progressive transfers of GI endoscopies from outpatient to day case procedures over time to attract a higher tariff. This may explain the 54% rise in English endoscopic rates between 2005-06 and 2009-19 in the ONS data.

Conclusion

The effective end of growth in inpatient, day case and outpatient hospitalisation rates in the Scottish secondary care sector after devolution, accompanied by stable GP consultation rates in the primary care sector, indicates that viewing healthcare as a "bottomless pit" in which continual growth in response to unmet need is inevitable is an unduly pessimistic scenario. Scottish post-devolution trends in performance suggest that a publicly funded health service based on cooperation between its component parts can achieve a stable equilibrium between supply and demand for primary and secondary healthcare. The major threat to this benign scenario in Scotland will be the inevitable decline in funding in the current unfavourable economic climate. In England this outcome is likely to be compounded by the additional destabilisation and fragmentation of NHS primary and secondary care resulting from implementation of the Health and Social Care Act.

Matthew Dunnigan

The Foundation Hospital Trust's Critical Friends

In the March Newsletter I described the way in which Foundation Hospital Trusts (FHT) had been created and how the weaknesses in their regulatory framework could invalidate their accountability. I thought I would use this presentation to highlight the mechanism by which the Directors of FHTs can identify and dismiss Governors who threaten corporate accountability.

The clinical priority

A half-hearted hospital centralisation plan 25 years earlier had left cancer services stranded on our old hospital site on the other side of the town. The transfer of this important facility had long been declared a clinical priority. Recent events raised the probability that unless Management were forced to declare their hand early and engage with our local knowledge base, cancer patients and those from other specialities were likely to find themselves short-changed.

The Governors' handicap

Governors were theoretically put in place to safeguard the interests of patients. In practice Governors become the uncritical stooges of Management. They are put in place by what might appear to be a democratic process. Supporters of FHTs identify themselves from the local population by enrolling as members. These ***best buddies*** of the Trust may then put their names forward for election as Governors. These well-wishers, once elected, are seen by Management as their ***Critical Friends***, and form the bulk of a heterogeneous committee called the Council of Governors.

The minimum activity required of them during their tenure is attendance at 3/4 of the quarterly Council meetings. For those wishing to learn more and hoping to play a more active role, they can avail themselves of a variety of workshops, presentations by hospital employees, and carefully controlled walkabouts through the hospital campus. In this learning process they are allowed to ask questions at official meetings but outside that arena questions to members of staff can only be directed via the secretariat. The vetting of questions by the secretariat is one of the ways in which the FHT can limit access to information and black out any window that might allow light to fall on sensitive areas.

In our FHT only two of the 16 public governors had any long-term working knowledge of the hospital – me and a recently retired charge nurse. As soon as we heard that Management had been secretly planning the transfer of cancer services, the pressure was on us to ensure that this did not become another clinical casualty. However, we were well aware that our goal might be frustrated by the Code of Governance.

The Code of Governance

You might expect a Governor, elected by the public, to represent the interests of the public in regard to the hospital's services to patients. You might therefore be surprised that, in this verbose Code of Governance which binds Governors to the hospital, the word "patients" is mentioned only twice, and the NHS Core Principles are tucked away in an appendix as some sort of after-thought. Furthermore, before Governors can take on their role they have to sign an oath of allegiance to abide by that Code in much the same way that members of the German armed forces had to swear an oath of allegiance to Adolf Hitler. Freedom of speech and freedom of expression is therefore not something that Governors are encouraged to invoke.

The first salvo

My journey on the road to infamy started about three months after the elections for the second Council of Governors had been held. (The first Council of Governors had been dissolved after their statutory three year tenure had expired). A somewhat inconsequential meeting of Governors had been convened to discuss the appearance of the front of the hospital.

Less than 30% of the Governors had bothered to attend and of those about half had already completed three years' service on the previous Council.

At the end of the meeting and after the Chairperson had left the room those present expressed general dissatisfaction with the way in which Governors were being short-changed by Management. It was decided to reconvene to a windowless "cupboard" off the main hospital corridor. This facility had been provided in response to the previous Council's repeated request for somewhere to assemble outside of official meetings. It was barely large enough for the seven of us to squeeze into. In a previous life it had been the depository for clinical waste from the adjacent ward! It contained benching, a couple of chairs and two PCs (irrelevant since none of the Governors had been given passwords to access the IT system).

We concluded this special gathering by deciding that what had become our ***focus group*** should meet again, on the morning just prior to the next official public meeting of the Council, in order to discuss any potentially contentious items on the main agenda. Our immediate problem was finding somewhere suitable for such a confidential meeting. My suggestion, to book a seminar room in the Postgraduate Centre (available to medical staff alumni), was accepted.

That meeting went ahead as planned and was a great success. At the following public session, which included a brief agenda item about the Radiotherapy services, we asked a few specific questions which appeared to wrong-foot the Board of Directors. Buoyed up by the usefulness of our preliminary meeting, I went ahead and booked a room for us to use before the next quarterly session. A short while afterwards I gave a long explanatory letter to the Chief Executive and Chairperson outlining a way in which the Radiotherapy problem could be resolved without it impinging on the long-term functionality of the rest of the hospital.

Within a couple of weeks the existence of our ***focus group*** had leaked out and, along with my letter which had clearly gone down like a lead parachute, I was given an hour long wrist slapping by the Chairperson with the Chief Executive and Lead Governor actively participating. (The post of Lead Governor is a somewhat superfluous appointment and in fact less than 30% of the Governors had voted for this candidate.)

My yellow card

When the Chairperson heard about our ***focus group*** she outlawed its existence, cancelled the room we had booked and arranged a private meeting of the whole Council of Governors on the morning of the next quarterly session. This could have been a sensible and logical outcome were it not for the fact that this private agenda failed to include time for our request to discuss the most contentious item on the public agenda, namely the location and content of the proposed new Radiotherapy Department. That item from the public agenda had been accompanied by a massive document which contained inaccuracies, irrelevances, and deceptions and omitted certain important factors. We really needed to thrash this out in private and get a consensus about the way forward.

Alas that was not to be!

The public session duly went ahead. I was able to allude to a few of these discrepancies, but the recommendation in this document was taken as approved without a vote or any undertaking to resolve the misinformation present in that dodgy dossier. After that meeting I emailed a few of my erstwhile Consultant colleagues to alert them to this undemocratic decision. I also emailed the members of our focus group about an issue concerning the Chief Executive.

Within a few days I was issued with a request to attend a disciplinary hearing of a specially convened meeting of the Governors Council at which my failure to abide by the Code of Governance would be discussed. That meeting went ahead, but I had to wait outside for its duration (2 hours) whilst the Chairperson laid out the case against me. I was then allowed to enter the forum, not to give an explanation for my alleged misdeeds, but to make a formal apology to the Council, agree to sign a written statement composed by the Company Secretary apologising for my alleged use of indiscrete language, and make a public apology at the next quarterly public session. Fortunately it did not require me to withdraw the substance of my criticisms.

I agreed.

The red card

This debacle left me and all but one in our ***focus group*** wondering how the secretariat had obtained the email which mentioned the behaviour of the Chief Executive. One member attempted to convince us that the Trust was hacking into our personal emails. The severity of the situation spurred me on to send a letter of complaint to Monitor.

At that time none of us realised that the person who had suggested email hacking had in fact copied at least one of my "incriminating" emails to the secretariat and had been granted total anonymity for his services. It wasn't until two months later that the penny dropped. In fact this overzealous Judas had continued to flood the secretariat with copies of confidential emails transmitted between members of our ***focus group***.

Another disciplinary meeting was set up. Other Governors were encouraged to send copies of any personal emails which I had sent to them. The charge was that I had contacted Monitor without telling the Lead Governor and that I had sent a number of information seeking emails to specific Directors instead of routing my queries through the secretariat.

The meeting was held in my absence. I was then suspended pending my submission of a written explanation for my actions. At the next session of this Kangaroo Court, held without allowing me to make any verbal presentation, my submission was discussed. Then a secret ballot was taken and on a majority verdict I was dismissed.

The Appeal

I received a formal letter from the Company Secretary stating my dismissal and advising me that I could lodge an appeal within 14 days, but inferring that issues other than my failure to abide by the Code of Governance would not be considered. The Trust's propaganda department made no announcement of my dismissal to staff employees nor to my constituents who had elected me. This news blackout was exceptional for a Trust that regularly massages the media.

I considered that appealing against my conviction would be pointless unless Monitor decided to caution the Board of Directors or, more importantly, to rewrite the Code of Governance and emphasise the implicit role of Governors to protect the local population from clinically inappropriate decisions made by any Board of Directors.

Conclusion

This has not been one of my best experiences. I was dumbfounded that the Trust could

resort to the same surveillance tactics used by East Germany's Stazi. Both the Chairman and Chief Executive come with a long track record in non-NHS management, but with neither of them living within the hospital's immediate catchment area, they appear to be able to short-change the local population with impunity.

Earl Howe had the opportunity to amend that Code of Governance when the Healthcare Bill was debated in the Lords. He chose to advise against the proposed amendment. Clearly Earl Howe either was totally ignorant of the complexity of the operational framework cemented by this Code of Governance, or else he was wholly complicit with the Government.

Effecting change in the NHS, except by governmental diktat, is difficult. Committees often prove unwieldy instruments of change. One of the presenters at the 2003 Emergency Services Collaborative, talking about changing the way in which medical emergencies might be handled, made a very apposite observation about the composition of committees. He stated that there were always high flyers, like eagles, championing meaningful change. There were the stick-in-the-muds, like donkeys, who were resistant to change. Finally there were those who run hither and thither, like a flock of sheep, wherever the Company sheepdog directs them. It is the actual proportions of these three components that decide the outcome and effectiveness of any committee.

In today's NHS, patients have in effect become the victims of a combination of political diktat and the vagaries of committee malfunction. Would it not be better for Ministries and NHS committees to be peopled by the doctors and nurses who are or have been actively involved in delivering healthcare? In regard to Foundation Hospitals, those ***Critical Friends*** who might champion the needs of patients are themselves prisoners bound to a Code of Governance that had been carefully crafted by politicians who lack our professional wisdom.

Mark Aitken

We have received this request from a television programme researcher. Anyone with information or views to offer, please get in touch with the contact below

Are you concerned about private patients being prioritised over NHS patients?

Do you know consultants who pursue their private practice at the expense of their NHS work?

Are private patients getting better clinical care than NHS patients in your hospital?

We are doing some preliminary research for a television programme and would like to hear from healthcare professionals.

At this stage, all conversations will be off-the-record and just for our research.

Please contact Caroline at caroline@fulcrumtv.com and 07931 303 318

The AGM and Conference 2012

will take place on
Saturday 6th October at
Friends Meeting House
Euston Road, London

Full details and application forms will be sent to all members in August

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