NHSCA

EDITORIAL June 2011

My last Co Chairs report began with the immortal words 'the NHS is back in the news again'. Since I wrote that it has hardly been off the front pages, and the news hasn't been good. Some of us (and we are surely old enough between us to have known better) were foolish enough to believe David Cameron when he made a pre election promise that there would be no more top down reorganisations of the NHS. No sooner had Cameron and Clegg stopped simpering at each other like a pair of nauseous newly weds in the No 10 rose garden than Andrew Lansley launched his Health and Social Care Bill on an unsuspecting world. Either he had stayed up all night for 6 weeks producing what the BMJ called 'Lansley's monster' or he had had it up his sleeve all the time, in which case someone was being economical with the actualité.

Some doctors welcomed it at first, seeing the attractions of 'more clinical engagement' and the usual patient centred blather. GPs in particular felt that this was their opportunity to improve the service for their patients and to put an end to permanent battles with their PCTs. Then they began to look at the rest of the Bill and it became clear to the majority that GP commissioning was just the bait in the bear trap of a Bill whose main aim is the accelerated marketisation and privatisation of the NHS.

At the same time the government had inherited the 'Nicholson challenge' to make £20 billion 'efficiency savings' over the next 4 years. While the politicians pretended that this could be done without affecting front line patient care the rest of us knew better. Jobs are already being lost, and services reduced, with a wide range of treatments being arbitrarily labelled as of 'doubtful clinical benefit' including such dodgy procedures as joint replacements and cataract operations.

GPs rapidly woke up to the fact that the blame for the cuts, closures and reduced treatment options would be laid firmly at their door. This combined with the prospect of Monitor breathing down their necks to make sure that the private sector got its well shod feet firmly under the table caused many to re-examine their initial enthusiasm for the proposals. It seemed that the price to be paid for getting their hands on the NHS budget was far too high.

Hospital doctors of course were never enthusiastic. Why should we be when the Bill hardly acknowledges our existence let alone our expertise? Despite paying lip service to having secondary care represented on commissioning consortia Pulse recently reported that the majority of commissioning leads did not want this. Some have commented that this would be a conflict of interest, which is quite interesting coming from a group 25% of whose members are reported to have a direct interest in private health care provision.

But more seriously the very existence of hospitals is threatened under the proposed 'reforms'. Hospitals rely on a predictable income to keep providing comprehensive services for the patients. Many of these services are of little interest to the private sector especially the emergency and acute work, where it is difficult to make a profit. Hospitals stand to lose income in three ways.

Firstly GPs are under huge financial pressure and will want to keep patients out of hospital and in the community – indeed it is already reported that they have been ordered to cut admissions by 15%. Some of this 'care in the community' will be appropriate but some may not. Either way it represents income lost to hospitals. Then there is currently no provision to stop private firms cherry picking hospital work, as they did with ISTCs. This inevitably leads to the now well recognized scenario of the private sector doing the profitable work while the NHS is left with the unprofitable work and the difficult and expensive patients.

And lastly there is – regardless of what ministers say – already competition on price. If a service is to change even slightly – for example is to be delivered in the community instead of in a hospital – then potential providers can compete on price. The private sector, with back rooms full of experienced lawyers and deep pockets to fund loss leaders, will inevitably win under these circumstances. More income lost to NHS secondary care.

Politicians have such a prejudice against hospitals and their professionals that they don't seem to have considered what will happen to them (and us) in the new climate of naked competition. Hospitals are organic structures whose many parts are mostly integrated rather than stand-alone. If you outsource orthopaedics that will have implications for A&E and then the rest of the hospital. And you can't mothball a department if the local GPs decide or are forced to tender that service to the private sector. If the outsourced service fails the local NHS department will not be there to pick up the pieces a year down the line.

Two recent events have shown how dangerous it is to outsource public services to the private sector. The threatened demise of Southern Cross, the biggest provider of care homes in the country, has attracted a lot of attention and many questions about the funding of social care. According to a recent article in the Guardian, in areas where Southern Cross have homes local councillors will not only take on the responsibility for the elderly people in their homes who are funded by the Council, but they also feel a moral responsibility to take responsibility for the self funded patients as well.

This is because in a civilised society social care cannot simply be allowed to fail, with its dependents finding themselves on the streets. But this has a bigger implication. If society chooses to place vital public services in the hands of the private sector then it will have to step in if the private sector fails or decides to withdraw. This means – as Tony Judt points out in his excellent book Ill Fares the Land – that the private sector takes the profits and the tax payer takes the risk.

The second big news story as I write this piece is the abuse of vulnerable patients uncovered by the BBC's Panorama in a home near Bristol. One alarming aspect of this story was that the senior nurse who went to Panorama with his concerns had tried to raise them through the approved route i.e. via local management and then when that failed through correspondence with the Care Quality Commission (CQC). They fell on completely deaf ears leaving him no choice but to go to the BBC. So much for the whistle blowing encouraged by our masters.

What this also highlights is the fact that the CQC cannot even police the current arrangements, let alone the host of new providers who will flood the market if Andrew Lansley's Bill goes through. How much more of this behaviour is already going on and how much worse would it be in a market place of competing providers, all chasing a profit and overseen by an understaffed CQC?

No-one pretends that the NHS is perfect but until now the pursuit of a profit has not been a factor in exposing poor behaviour. I also believe the NHS ethos of public service means we all work together to help prevent this sort of thing. Once the workforce is fragmented along with the service and we lose the protection of national terms and conditions it will be much more difficult to get staff to speak up when they see problems in the workplace.

For those who would like a clear overview of how the politicians have got us and the NHS into this mess I recommend The Plot against the NHS by Colin Leys and Stewart Player. It lays out clearly the intention of successive governments to turn the NHS into a kite mark attached to 'any willing provider' and details how ministers and the private sector have worked together below the radar to bring this about - a situation which the public don't want and would never have voted for if it had appeared in a party manifesto. So dump your normal holiday reading and pack this instead, it's gripping!

The daily parade of news about the NHS has of course given NHSCA officers and members plenty of opportunity to make our views felt via letters in the papers, talks and other media exercises. I recently sat on the panel for a Guardian version of Any Questions on the NHS. After we panel members had all been allowed to state our position on the NHS there were naturally questions from the invited audience,

one of whom rose to declare that I was 'crazy and completely off the wall'. I took this as a compliment coming as it did from a denizen of the private sector.

In pursuit of spreading the truth I also attended a tea party at the House of Lords (excellent sandwiches). When I arrived on my bike I asked where I could chain it up as there were no bike racks visible. 'Don't worry miss' said the officer on guard, cradling his semi automatic, no-one will touch it while I'm here.

There have been many invitations to talk about the Bill and its implications, and our sister organisation KONP is currently swamped with requests for speakers. I know Peter has circulated a message asking for volunteers to talk around the country and I'd also encourage members to take up this invitation. It really is a gratifying experience, with sympathetic audiences who are very receptive to our message but utterly baffled by the complexity of the legislation and the spin accompanying it.

It has been particularly encouraging to be invited to talk to student groups, who have become politicized by the treachery of the coalition over tuition fees. They are keen to take up the cause of the NHS and public services in general and have formed several organisations to fight the 'reforms' including the excellent Big Society NHS. It is well worth visiting their very good web site **http://bigsocietynhs.wordpress.com** to see how the younger generation do things.

And talking of websites I'm sure most of you have enjoyed Sean the singing binman and his Lansley rap on Youtube **http://www.youtube.com/watch?v=Dl1jPqqTdNo**, which has had nearly 400,000 hits. He manages to explain a Bill the size of a telephone directory in 3 minutes, while destroying the Secretary of State at the same time. Voltaire said 'O God, make our enemies look ridiculous'. Congratulations to the singing binman for doing exactly that. I believe motions have been submitted for the BMA conference calling for him to be made an honorary member, we can only hope.

Talking of the BMA, I have said little about their position on the Bill as I would like to keep my place on BMA Council. It has been particularly useful this year to have three of our members (myself, Anna Athow and Clive Peedell) on Council. There was much debate over the need for a Special Representatives Meeting to discuss the Bill. After a lot of hot air and the threat of divisions having to call for an SRM (congratulations to Wendy Savage for organising that) we eventually had our day out. The meeting was packed and a vote passed calling for withdrawal of the Bill. This message went out loud and clear to the media, and since then the BMA's position has been largely perceived as one of opposition.

We have been lucky to welcome Clive as the new Co chair of the NHSCA. He made a splash with his open letter to the BMA in the BMJ (1), and with a recent piece (2) in the same august journal on why the 'reforms' will inevitably lead to privatisation of the service. Elections to council will take place again next year, and I urge those of you who are BMA members to keep an eye open for NHSCA members who will be standing for re-election.

At the same time thanks must go to Chris Burns Cox (recently stood down as Co Chair) for all his hard work and support, and to the new custodian of our website, Mark Aitken, who I'm sure would welcome suggestions for items to go on line. And last but certainly not least to our very industrious president without whom the NHSCA would not survive for long.

Finally thanks go to all of you who support the NHSCA through your membership and your encouragement. The NHS – more popular now than ever with the public – is an affront to the private sector and to the true believers in a market place for everything. It is a pity that the fight to protect the NHS is a perpetual feature of the medical political landscape. For the sake of our patients we have to win that fight.

(1) http://www.bmj.com/content/342 bmj.d7.full?sid=e259ebba-e124-4e6d-b0d7-4a5828ed10ec

(2) http://www.bmj.com/content/342/bmj d2996.full?sid=e259ebba-e124-4e6d-b0d7-4a5828ed10ec

JACKY DAVIS
Co Chair and Guest Editor

What do GPs think of these Health Reforms?

Amongst consultants at the moment there is a great deal of uncertainty about the proposed health reforms we see before us. What is it all about? Are the reforms really that bad? What does GP led commissioning mean? Are GPs up to it? Why are consultants being left out?

I am a GP working in north Lancashire and I am a member of BMA UK Council. I also speak for Keep Our NHS Public **(www.keepournhspublic.com)**. I am part of a successful locality commissioning group but I am very much opposed to the current Health Bill that has been proposed by this Tory led coalition government. Let me tell you why….

I very much believe in the founding principles of the NHS - a service available to anyone, free at the point of use and publicly funded with equitable access no matter what the complexity of your illness might be.

To achieve this doctors from all parts of our profession should work together to give the best we can for our patients. There should be no element of 'profiteering' as a by-product of the care we give. These reforms and the changes that could come about will see this happening and that is why I have been opposed to them. There could also be a fundamental shift in the trust patients put in us as doctors and this could have far reaching consequences.

My area of Lancashire have been commissioning for 4 years now. Recently we have been given more authority and we are working closely with our DGH consultant colleagues to improve care pathways and streamline them for our patients. We have done all this with no legislation in place, no convoluted market driven Health Bill in place and all with the co-operation of many colleagues across many specialties. This is what we need to fight to retain - commissioning rolling out as we do it here in Lancashire but without opening up the NHS to the private sector in a much bigger way than Labour ever did in their time in office.

The politicians state they will 'never privatise the NHS'. As always the words a politician utters may not always mean what they appear to on face value. The proposed reforms intend to open up the NHS to the private sector so that they will be able to bid for many services currently offered by a DGH. Indeed the private sector will be seeking out those services that return quick profits – the 'cherry picking' scenario we hear about. Also the vast legal and commercial infrastructure they have means they are streets ahead in tendering for these services and they may also be able to 'loss lead' in order to get a foot in the NHS door.

This is when local NHS services could destabilise. Losing certain services on the face of it may not seem too drastic but a DGH is like a game of Jenga. All stacked up together it looks solid and robust but remove the odd piece here and there and you find the whole Jenga stack falls down. This is what could happen to our DGHs under these reforms once the private sector get their teeth into secondary care.

One part of the Health Bill suggests that when 'savings' are made on local NHS budgets then these savings are distributed to the local doctors at the end of the financial year. Imagine the scenario. A patient is sat in front of you requesting a certain procedure that you don't think is in their best interest clinically. As you explain this to the patient they are thinking to themselves – 'is this doctor fobbing me off so the savings they make can be divvied up between them all". Never before has this occurred in the NHS and if we allow this to come about we will lose our place as the most trusted profession in the country – possibly forever. There would be no going back from there. A shocking thought.

So I feel it is vital we fight to oppose these coalition driven reforms. Changes may well be proposed to the Bill but they are unlikely to remove the market driven NHS this coalition wishes to see.

We must fight to retain our role in leading change in our local health economy, free from the shackles of top down bureaucracy we suffer at present and we must use all our might to stop the NHS being turned into nothing more than a kitemark logo with a fragmented health service open up to the City to make as much profit as they can from our ailing patients.

DR DAVID WRIGLEY
GP in Carnforth, Lancashire
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What's happening in London?

The rapid, huge scale of cuts and privatisation that is taking place in London is representative of what is happening throughout England.

The commissioning clusters are having their funding cut by the Department of Health and NHS London and are decommissioning services from the acute hospital trusts in their areas. These acute hospital trusts are told they must stick to the reduced budgets otherwise they cannot become Foundation Trusts (FTs).

Out of London's 29 acute trusts (some with multiple hospitals), 9 have become FTs; Chelsea and Westminster, Guy and St Thomas', Homerton, Kings College, Moorfield's Eye Hospital, Royal Brompton & Harefield, Royal Marsden, University College and Hillingdon.

Some are aspiring to become FTs like the Whittington, Lewisham, and Croydon. They are using the acquisition of the community services in their areas to become "integrated care organisations", to assist this goal. Kingston, St Georges, North Middlesex, Royal National Orthopaedic Hospital. (RNOH), and South London Healthcare Trusts (SLHT) also aim for FT status.

Barking Havering and Redbridge University Hospitals NHS trust (BHRT), Royal Free, and Imperial, have financial problems and seem to have put their FT aspirations on hold.

Some trusts have been saddled with "deficits" and have clearly been instructed by the commissioners to take the route of merger, like Whipps Cross, Newham, Ealing, West Middlesex and Epsom & St Helier.

Other trusts have been systematically underfunded and run down by the commissioners for a long period, preparing them for complete closure as DGHs. Replacement of the asset stripped sites with a collection of private units is planned; elective surgery, walk in centre, outpatients, rehab, primary care and diagnostics. This is at an advanced stage for QMH Sidcup and Central Middlesex and is the plan for KGH Ilford and CFH Enfield. In every case, merger preceded the closure plans.

Central Middlesex in Harlesden is an example of how a traditional hospital site in an area of great clinical need was asset stripped of land to finance a modern PFI building, then subjected to the gradual removal of first maternity, and now parts of paediatrics and emergency surgery. It seems to be undergoing piece meal privatisation of its clinical services, starting with the front door urgent care centre.

Privately owned urgent care centres are also springing up at the front of A&E departments at, St Thomas', Hillingdon, Whipps Cross, North Middlesex and others and seems to represent an effort by the private sector to take control of triage, i.e. hospital admissions.

These plans by the coalition are a rehash of the Darzi Healthcare for London plan of the last Labour government, executed by another route. Secretary of State for Health Lansley's photo shoot performances outside threatened hospitals last Spring, was nothing more than mendacious electioneering.

The clinical implications of these cuts and reconfigurations are being hidden. The damning reports of the Care Quality Commission into the maternity units at BHRT, Kingston and SLHT lifts the lid on the dangerous consequences of constant cost cutting and understaffing. BHRT was running unsafe services, short of 50 midwives. This untold tale is yet to come into the open. Mid Staffordshire type disasters are being created.

It is clear that the coalition government is going about decimating the provision of acute hospital care in London, through a combination of Foundation Trustification on the one hand and merger as a prelude to DGH closure on the other. Both ways lead to private sector involvement and asset stripping of land and infrastructure. RNOH is considering handing over its entire running to a private company.

The rapacious profit making by the PFI construction companies such as in Barnet - where 67% profits have been made by investors - is driving the cuts and closure programme. These companies could take ownership of the hospitals at the end of their contracts.

Amalgamation of acute hospitals with community services is being used to create giant "integrated care organisation" FTs, which control hospital and out -of - hospital care in their areas.

The Health and Social Care bill would give these FTs new powers to behave like commercial organisations, with freedoms to borrow from banks, and treat unlimited private patients and become social enterprises. In essence they would be self governing trusts and own their own assets, no longer being state owned. They could end up being bought and sold on the market. The corporatisation of NHS hospitals and community care is taking place under our eyes.

Were the coalition to get away with the corporatisation of GPs by forcing them all to join cash limited GP commissioning consortiums (GPCCs), the infrastructure for a completely corporate run NHS would be in place. This is the meaning of the Health and Social Care Bill.

The whole of the NHS would become one giant public private partnership, with the NHS providing the funding and all the delivery coming from private corporations. With profit as their main aim and a truncated budget, hospital charges would be on the agenda. Already the new CE of Whittington hospital has said that the hospital would charge for non elective care, so as to become a FT.

Commissioning itself is being more and more decided by leading figures from the financial world that sit on the boards of the Commissioning clusters and trusts and under the health Bill would populate the new NHS commissioning board and GPCCs.

It is clear that the Health and Social care bill is incompatible with a publicly owned and provided NHS and should be withdrawn.

ANNA ATHOW
General Surgeon

A Request for Support

Dear NHS Consultants' Association,

Thousands of graduates from across the UK, wishing to study medicine are being blocked from continuing their education by government reforms.

Currently, if you are a graduate you are not eligible to apply for a student loan to cover course fees for a second degree. With the sudden increase in tuition fees, graduates will now pay £9,000 for year-one of the four-year, graduate-entry medical course, instead of £3,375; an increase of 166%.

The NHS Student Bursary, which covers course fees and provides a means tested maintenance grant for years 2-4 of the graduate entry medicine degree, is also now under review by the Department of Health. The Bursary provides support not only for graduate medical students, but also undergraduate medical students in their 5th and 6th year of study and also dentistry, nursing and allied health students on their courses. If it is removed, the price of a graduate medical degree will skyrocket 966% from £3375 to £36,000, in the space of just one year.

Graduates bring valuable skills and experience, gained from previous degrees and working in other professions and are vital in ensuring the diversity of the medical workforce. The 4-year graduate entry course was introduced specifically to encourage graduates into the profession and is offered by 16 medical schools to over 3000 students.

The government white paper, setting out plans for higher education, is expected in the summer of 2011 and we must lobby the Government to build in concessions for medical students and graduate medical students to ensure that medicine is not restricted to only those from the most privileged backgrounds.

A number of graduates, wishing to apply for a degree in medicine, have created an e-petition, www.savegem.co.uk which we would urge you to sign. We have also been writing to our local MPs, David Willetts, Higher Education Minister, Vince Cable, Secretary of State for Business, Innovation and Skills and to the Department of Health; we would urge your readers to please do the same.

If you would like to read further information on this issue and graduate case studies, the British Medical Association have published a briefing paper, which you can access here http://www.bma.org.uk/images/fundingforgraduatemedicalstudents_tcm41-206861.pdf

In closing, what we are asking for is fair access to medicine for those who are academically capable and have the potential to become good doctors, not just access for those who can pay £9000 a year, up front.

Thank you for your time,

REBECCA MCKNIGHT
(a prospective, graduate medical student).

NHS - Safe in Who's Hands?

When David Cameron was elected last May, he assured us that the NHS was safe in his hands and that there would be no more "top down re-organisations". However, he forgot to mention the 2007 blue print produced by himself and Andrew Lansley for the Health & Social Care Bill which is now before us.

In spite of the clear content of the Bill, Cameron and Lansley continue to insist, in good Orwellian fashion, that it does not constitute NHS privatization. However, their advisors seem to disagree.

Mark Britnell (KPMG) last year opined "The NHS will be shown no mercy and the best time to take advantage of this will be the next couple of years," and "In future, the NHS will be a state insurance provider and not a state deliverer." Meanwhile, David Bennett (ex-McKinsey), the chairman of Monitor, who, under the original provisions of the Bill would have been responsible for promoting "competition", has more recently stated that "The NHS is ripe for dismemberment". All the while, David Nicholson, chief executive of the NHS, has made it clear in multiple meetings that the provisions of the Bill must be rolled out regardless of the legislative outcome, and with increasing momentum during the Governments "listening pause". Yet, there has been no response from Mr Cameron who has staked his personal reputation on his health plans.

Nick Clegg, by contrast, has flip-flopped between initially assuring us that the Bill was "safe" and "progressive", to now questioning new aspects on an almost daily basis, while holding to its central tenet of increasing private sector provision, worrying only about the rate at which this occurs. What of the Opposition? Ed Miliband and John Healy seem so hobbled by their party's recent health record that all they can do is shout "Naughty, naughty, naughty!" from the wings, while failing to take centre stage with a promise to renationalise our health service, should they ever take power.

So much for the politicians. What of the BMA? Its special representative meeting in March was advised by the chairman of Council, Hamish Meldrum, not to pass a vote of "no confidence" in the Secretary of State nor to support a motion calling for the Bill to be "rejected in its entirety". This effectively killed the full impact of the profession's opposition. The BMA continues to try and extract tasty gobbets for a few GPreneurs from a thoroughly rotten egg in spite of clear opposition from its consultants and a proven majority of rank and file general practitioners.

All the while, Cameron and Lansley peddle their lie to the electorate that, contrary to all the evidence, the Health and Social Care Bill does not mean NHS privatisation.

We need an Emperor's New Clothes Moment. That would entail the BMA coming out and stating clearly that the Government is misleading the country with regard to privatizing the NHS. At present, this seems unlikely.

Right now, I'd love to see a safe pair of hands cradling our embattled Health Service, but there's no sign of a credible advocate on the horizon.

KEVIN O'KANE
Emergency Medicine, London
Chair, London Council of BMA

Who do you think you are kidding, Mr Lansley?

Repeated Government denials about NHS privatisation don't stand up to scrutiny.

In response to widespread criticism of the proposed NHS reforms, Andrew Lansley, David Cameron, Nick Clegg and George Osborne have all repeatedly claimed that there will be"no privatisation" of the English NHS [1]. The Department of Health website even states that "Health Minsters have said they will never privatise the NHS" [2].

However, these claims and promises fail to acknowledge the evidence that privatisation is an inevitable consequence of many of the policies contained within the Health and Social Care Bill.

The meaning of privatisation is complex covering a range of ideas in law, politics, economics and philosophy [3], but the World Health Organisation (WHO) has defined privatisation in health care as *"a process in which non-governmental actors become increasingly involved in the financing and/or provision of health care services"* [4]

Thus, the Government's attempts to deny NHS privatisation by claiming that that NHS services will remain publicly funded and free at the point of delivery, does not escape the WHO definition of privatisation if provision of services are delivered by non-governmental actors e.g private and third sector organisations. This is clearly a stated objective of the reforms.

Furthermore, some authors have attempted to create a coherent taxonomy for the act of privatisation. Commander and Killick's classification of privatisation as five main types is widely quoted and is listed below [5]. A more detailed typology of privatisation described by Savas concurs with all of these mechanisms [6].

a) Divestiture or outright sale of public sector assets in which the State divests itself of public assets to private owners

b) Franchising or contracting out to private for-profit or not for-profit providers

c) Self management wherein providers are given autonomy to generate and spend resources

d) Market liberalisation or deregulation to actively promote growth of private health sector through various incentive mechanisms

e) Withdrawal from state provision wherein the private sector grows rapidly as a result of the failure on part of the Government to meet the healthcare demands of the people

The proposals contained within the Health and Social Care Bill fulfil all of the above criteria for privatisation in the following ways:

a) The proposed legislation for all Foundation Trusts to become Social Enterprises is a form of "divestment by donation to employees" [6], which represents a mutualisation process. This policy places hospitals outside of state control and out of the public sector. Kingsley Manning, business director from Tribal Consulting famously stated that this policy would result in "denationalisation through mutualisation" which "could see the transfer of billions of tax-payers' assets to employee controlled businesses" [7]

b) A key part of the Bill involves the use of "Any Willing Provider" that will ensure contracting out to private and third sector providers. In addition, there will also be contracting out of the management of commissioning to the private sector through the framework for external support for commissioning (FESC). This was initially introduced by New Labour and prompted the former Secretary of State for Health, Frank Dobson to state that "If this is not privatisation of the NHS, I don't know what is. It is about putting multi-national companies in the driving seat of the NHS." [8]

c) Self management is consistent with the Foundation Trust model which gives greater autonomy to generate and spend resources. The abolition of the cap on private income will stimulate a drive to increase income by treating more private patients. Foundation Trusts will also be allowed to borrow money from the financial markets to invest.

d) The Bill is clearly a blueprint for creating an open market in healthcare. Monitor has been tasked with actively promoting market competition by encouraging a plurality of providers from the private and third sectors. Andrew Lansley has stated that "Maximising competition is the first guiding principle" for his reforms[9]

and he initially tried to introduce "price competition" in a move to replace the current quasi-market of fixed pricing, but has since been forced to backtrack on this.

Moreover, if the NHS is opened up EU competition law as suggested in a recent technical argument published in the BMJ[10], the Government could be rendered powerless to prevent services going out to tender in the European healthcare market.

e) Section nine of the Bill removes the duty of the Secretary of State for Health to provide comprehensive healthcare and is a classic example of removing state provision. In addition, in section 10, the Bill states that: "A consortium does not have a duty to provide a comprehensive range of services but only "such services or facilities as it considers appropriate".

This withdrawal of state provision for many services will be accelerated by the QIPP initiative of £20 billion of efficiency savings (advocated by the private management consultants McKinseys under the previous Labour Government). Waiting lists and waiting times are rising, which is associated with increased uptake of private healthcare insurance and the use of private providers.

The Health and Social Care Bill will therefore result in increasing privatisation of the English NHS according to all five of these criteria. In fact, this is actually in keeping with the supply side economic policies of this Government, which promote a privatisation agenda across the entire public sector, as the Prime Minister promised in February this year ahead of the delayed public sector reform White Paper. [11]

In summary, the coalition Government's repeated denials of NHS privatisation do not stand up to scrutiny and thus the public are being misinformed and misled about the objectives and consequences of the Health and Social Care Bill.

References:

[1] Available @ **http://www.bbc.co.uk/news/uk-politics-13325442 (accessed 9/5/11)**

[2] Available@http://healthandcare.dh.gov.uk/question-will-%E2%80%98any-qualified-provider%E2%80%99-lead-to-privatisation-of-the-nhs-with-private-companies-cherry-picking-the-easiest-cases-and-services/(accessed 9/5/11)

[3] Starr P "The Meaning of Privatization," Yale Law and Policy Review 6 (1988): 6-41.

[4] Muschell J. Technical briefing note on privatization in health. Geneva: World Health Organization; 1995. WHO/TFHE/TBN/95.1.

[5] Commander S, Killick T. "Privatisation in developing countries: a survey of the issues", in Paul Cook and Colin Kirkpatrick, eds., Privatisation in Less Developed Countries. 1988 (Brighton: Wheatsheaf Books).

[6] Savas. A Taxonomy of privatisation strategies. Policy Studies Journal, Vol. 18, No.2, Winter, 1989-90

[7] Manning K. Liberating the NHS. The next turn in the corkscrew. Tribal Consulting 2010.

[8] Dobson F. Quoted in the Guardian. June 30th 2006. Available @ http://www.guardian.co.uk/society/2006/jun/30/health.politics. Accesses 10/5/11

[9] Lansley A. Extract from: 'The Future of Health and Public Service Regulation' Speech. 09 July 2005. Available @ http://www.andrewlansley.co.uk/newsevent.php?newseventid=21 (accessed on 11/5/11)

[10] Dunbar-Rees R, McGough R. Challenges of EU competition law for general practice commissioning. BMJ 2011;342:d2071

[11] Hope C. "David Cameron promises public sector revolution". Daily Telegraph 20/2/11. Available @ http://www.telegraph.co.uk/news/politics/8337237/David-Cameron-promises-public-sector-revolution.html. Accessed 11/5/11

CLIVE PEEDELL
Co Chair

NHS Scotland a role model for reform, says study

(a recent website press release)

The NHS in England may be in turmoil, but a major new academic study claims its Scottish equivalent should serve as a role model for the public sector.

According to the findings of a two-year report, post-devolution healthcare in Scotland represents a "groundbreaking" approach to the art of industrial relations.

It has taken "arguably the most ambitious labour-management partnership so far attempted in the UK public sector" and made it work, say experts south of the border.

Academics from Nottingham University Business School studied the workings of NHS Scotland in an effort to enhance understanding of partnership agreements.

In recent years such arrangements have come to cover around a third of all public sector employees across Britain, some 1.5m of them working in the NHS.

After devolution the NHS in England increased its reliance on a market-based approach – now one of the various controversies surrounding its future direction.

By contrast, NHS Scotland set about developing partnership agreements at national and board level as part of a strategy to engage staff in improving services.

The result, according to a study funded by the Economic and Social Research Council, is an "incredible common agenda" among interested parties from all quarters.

Research co-author Dr Peter Samuel said: "Although partnerships are found elsewhere in the public sector, NHS Scotland's stands out as distinct and novel. It has survived for over a decade, defying reorganisation and changes in administrations, and it can offer valuable lessons in how to improve industrial relations.

"Anyone wanting to understand how government, employers and staff should work together to deal with strategic and organisational challenges can learn from it."

The study examined the frequency, scope, behaviour and "voice" of meetings involving various forums associated with NHS Scotland's partnership agreements.

Chief among these were the Scottish Workforce and Staff Governance Committee (SWAG) and the Scottish Partnership Forum and Secretariat (SPF).

As well as attending many forums in person, researchers painstakingly analysed the published minutes from scores of meetings held between 1999 and 2009.

The study praises the way NHS Scotland separates broad-ranging debates over strategic issues from detailed discussions over specific workplace policies. It also highlights the lack of repetition — the SPF addressed more than 133 topics in a decade — and the near-absence of a "We've heard all this before" mentality.

Dr Samuel said: "The policymakers of NHS Scotland clearly concluded the only way to deliver better healthcare was to improve the way staff were engaged. This led to the establishment of various structures at national and local levels to give staff more say in decisions affecting their working lives and healthcare provision.

"NHS Scotland has even passed into law a 'staff governance code' that compels all its health boards to engage and involve staff and their representatives.

"This innovation in industrial relations is

arguably one of the biggest examples of industrial democracy to be found anywhere in the world – and they have made it work."

Nottingham University Business School is an acknowledged leader in teaching and research in the fields of sustainability, innovation and entrepreneurship.

Dr Samuel carried out the study with Professor Nick Bacon, a fellow expert in human resources management, with the full co-operation of NHS Scotland officials.

The pair also examined the workings of NHS Wales, whose own approach currently sits between Scotland's and England's but is moving closer to the former.

Dr Samuel said: "Our research suggests NHS Scotland and NHS Wales are well placed to cope with the harsh realities of any future squeeze on the public purse. NHS Scotland in particular has a mutual commitment to improving patient care and staff involvement, with everyone sharing an incredible common agenda.

"On the other hand, the future for industrial relations in public sector organisations that choose to pursue purely market-based reforms might prove stormy.

"But it's still not too late for public service managers and staff representatives to start building a meaningful dialogue around improvement rather than downsizing."

Dr Samuel has kindly sent us the original report, entitled ***"Evaluating Labour-Management Partnership in NHS Scotland: first-findings"***, published in January 2011. Space precludes publishing the full 18 page report but key sections are reproduced below:

1. Introduction and Background

This report presents first-findings from an ongoing independent evaluation of labour-management partnership in NHS Scotland conducted by Nottingham University Business School. With the express support of the NHS Scotland Chief Executive in 2009 the Investigators secured funding from the Economic and Social Research Council (ESRC) to undertake this work at no cost to NHS Scotland or the Scottish Government. This funding covered the first phase of a two-stage investigation. The first phase explores partnership at national-level over two years. Fieldwork for this project commenced June 2009 and will complete June 2011. The intended second phase, for which we have applied for further ESRC research funding, will evaluate partnership in Area and Special Boards across NHS Scotland and will start August 2011.

This research with NHS Scotland aims to increase understanding of the partnership agreements that have developed over the last decade to cover one-third of public sector employees in Britain by 2007. Most of these agreements were signed in NHS Scotland, NHS Wales and then the NHS in England to cover nearly 1.5 million health service employees. NHS Scotland has led the way in developing partnership agreements at national and board level following devolution as part of a strategic approach to engaging staff in improving health services and to build staff commitment to deliver these improvements. The Scottish Office in 1999 mandated a partnership structure for NHS Scotland in which employers and staff-side representatives work together to modernise health policy and service delivery. This involves staff representatives in developing plans and managing health services rather than the traditional industrial relations approach of consulting and negotiating with staff over changes after making key decisions.

As partnership has become embedded in NHS Scotland in the past decade these arrangements have developed into probably the most ambitious and important industrial relations innovation in the British public sector. Although partnership is found elsewhere in the Scottish public sector and elsewhere across Britain, partnership in NHS Scotland stands out as a distinct and novel approach that has survived for more than a decade and withstood changes in administrations and NHS reorganisation. Studying this pathbreaking approach may offer general lessons in how to improve industrial relations, help to identify the factors that sustain such arrangements over time, and understand how government, employers and staff-side representatives may work together to deal with strategic and organisational

challenges in the years ahead. Working closely with the Scottish Government, employers and staff-side representatives, our aim in developing and conducting this reseach is therefore to increase understanding and awareness of how partnership in NHS Scotland operates, analyse the main strategic and organisational challenges, assess how these challenges have been addressed, and identify and explain the main outcomes.

NHS Scotland's national-level partnership merits careful assessment for the following reasons:

- it is the longest established national-level NHS partnership agreement in the UK;
- the partnership arrangements aim to provide for high levels of staff involvement in improving patient services;
- it is legally mandated and backed by broader Staff Governance Standards;
- the partnership approach receives significant support from the Scottish Government, employers and staff-side representatives;
- it is arguably the most ambitious and comprehensive labour-management partnership so far attempted in the UK public sector.

This interim report is organised as follows:

- research objectives and method;
- first-findings (frequency, scope, voice and behaviours);
- benchmarking against the Welsh Partnership Forum (WPF);
- the proposed second study.

A comprehensive report will follow the end of the funding for this first phase of our project in mid-2011.

2. Research Objectives and Method

The current study aims to describe the development of partnership in NHS Scotland, the challenges encountered, and the potential of partnership for improving public health services.

This focus here is primarily on consultation processes as the *'basic tenet of partnership in NHS Scotland is that all staff have the right to be fully informed and consulted at the earliest possible stage, in matters relating to their working life'* (Scottish Partnership Forum website).

Labour-management partnerships often produce considerable debate in organisations that set up such arrangements. On the one hand, frequent and well-attended meetings of broad scope, with agendas reflecting the interests of all participants, should increase commitment to joint problem-solving and help sustain partnership arrangements in the future. On the other hand, infrequent partnership meetings of a narrow scope, confined to a limited agenda with the views of one group dominating, may not increase commitment to working together.

Given these debates, this interim evaluation of national-level partnership in NHS Scotland concentrates on four key features: frequency, scope, voice and behaviours in partnership meetings. The **frequency** of partnership meetings is important because involvement in key decisions needs regular and well-attended partnership meetings. Infrequent and poorly attended meetings suggest that key decisions are made outside these meetings. The scope of partnership meetings is also important as meetings of broad **scope** extend staff-representatives' involvement in a range of issues beyond those covered by traditional collective agreements. If partnership meetings do not cover a broad range of strategic issues then this may limit the influence of such forums, and participants may feel that they are not involved in discussing the most important issues. **Voice** is also crucial in partnership, as active participants contributing towards the discussions have opportunities to influence key policies. Finally, cooperative **behaviours** from all the participants help to develop a positive partnership climate. This is rarely studied empirically in contemporary industrial relations research. Ideally employers and staff representatives actively work together to address problems and to identify the best solutions. This requires all sides to share information and make positive suggestions *before* committing to a course of action. A key test of the effectiveness of partnership, therefore, is for all participants to show high levels of trust and share a commitment to work together.

We are observing partnership in practice in meetings of the following inter-related national-level forums:

- Scottish Partnership Forum and Secretariat (SPF);
- Scottish Workforce and Staff Governance Committee and Secretariat (SWAG);
- Scottish Terms and Conditions Committee (STAC);
- Human Resource Executive Strategic Forum;
- Employee Directors Forum.

We focus primarily on the SPF in this report and to a lesser extent SWAG with a full analysis of data from SWAG still ongoing. We observe the other forums to understand the context of partnership. The key methods we have employed thus far include:

- Observations of forums classifying behaviours by scope, voice, behaviours and time-spent;
- Documentary analysis coding the minutes of all published minutes of forums to assess scope, voice, behaviours and outcomes over time;
- Semi-structured interviews with participants to clarify issues concerned with origins, process and outcomes.

These methods, which we have successfully employed in other studies of labour-management partnership in Britain, will continue to be employed until the end of the funding for this study in June 2011. Early in 2011 we also intend to conduct a survey of the participants of national-level partnership forums and conduct more interviews with participants.

3. First-Findings

This section focuses on the frequency, scope, voice and behaviours of the SPF 1999-2009 (and SWAG 2006-2009). It then compares the SPF with the Welsh Partnership Forum (WPF) 2004-2009 across the same themes. Data collected since 2009 at national-level in NHS Scotland are currently being processed. Overall the findings suggest the SPF and SWAG provide for frequent and wide-ranging staff involvement on the key strategic and workforce issues in NHS Scotland. In SPF meetings the participants exchange information and work together on key strategic issues with little conflict expressed. We highlight several areas where, in our view, partnership processes may be further improved.

3.4 The Next Phase 2011-2013

Our interim findings thus far, outlined above, suggest that at national level this unique tripartite partnership involves a shared commitment to improve patient services and significantly extends the scope of staff-side involvement over a broad range of strategic and workforce governance issues.

The second phase of our research builds on our current study to analyse, in-depth, the contribution of Area Partnership Forums (APFs) in 22 NHS Scotland Health Boards to managing the challenges of increasing health service demand, the need for cost-savings and efficiency gains, while also delivering the Scottish Government's health improvement agenda. The findings will have important lessons for NHS industrial relations in particular and UK public sector industrial relations in general.

To further understand these important issues, the second phase involves a two-year project to identify the key factors for effective partnership working in NHS Scotland at both national and local levels as the implications of public sector expenditure restrictions unfold. National-level partnership forums have developed common approaches but it is expected that local partnership forums will lead the way over the next few years to develop optimal solutions to the issues faced.

The full Interim Report is available electronically from NHSCA.

As indicated, this is very much work in progress and we would be interested in comments from members, particularly those working in Scotland or Wales with practical experience of what is described.

Dr Samuel welcomed our interested and has expressed willingness to update us on the work at our AGM in October.

PETER FISHER

A Better Way Forward

Introduction

Far from allowing the division of GPs from Consultants in an unseemly dash for clinical power, as a GP for 30 years and a survivor of numerous "reforms" , I feel all crafts should unite against the Health and Social Care Bill. Hospital staff have taken a bashing over the last decade or so, and now it appears the assault on GPs will intensify when we hold the "poisoned chalice". Politicians devoid of honest argument wanting to promote their ideology to mark their place in history often use the cliché "no change is not an option" . Well there certainly is a better option, and it's a far sweeter medicine and would have widespread support. This is not meant to be a point-by-point critique of the Bill, which has been done elsewhere, but an argument promoting a better way forward. I don't want a compromise with even a watered down version of Lansley's illogical tampering which will leave him trying to rival Dr Beeching.

The pumping heart of a good healthcare system is a decent GP-Consultant relationship working for the patient.

They want and need co-operation and collaboration between their advocates, as well as continuity and co-ordination, producing seamless care. All this should be on the bedrock of the genuine founding principles of the NHS. Lansley's revolution is heading in the totally wrong direction, but he continues what Blair started 10 years ago. It must be seen within the context of what the Government wants to do with all public services—reduce them to core provision run by private companies. We will end up with commercialisation, wasteful "pseudo-competition" (some enforced) , damaged doctor-patient relationships, and threats to confidentiality education and training . It is unnecessary, unfair , inefficient , wasteful and expensive ,and the Coalition has no mandate . A golden opportunity was missed a decade ago when New Labour did a complete U turn and headed down the market route—again with no mandate.

Is it really too late to have a NHS with patients, GPs and Consultants at it's heart and get the politician's dangerous experiments and ideas off our backs?

Politicians interfering in the Health Service are amateurs trying to play a professionals' game. Andrew Lansley may have had his portfolio for 7 years , but it may not be long before he is dealing with Transport or the Environment. The increasing trend for our "leaders" to ignore expert advice stems from evidence not fitting their ideology.

Lansley's reforms, he says, are necessary to give patients more choice, improve outcomes and save money. His boss, David Cameron, adds that he doesn't see why patients should settle for a "second-rate" service. He is telling patients what they want instead of listening. My patients look at me bewildered when I offer them a choice of hospitals. Without exception they want a good efficient clean local DGH—just like the one in my area that Lansley is at present winding down, despite pre-election promises. Patients have been told they want choice because without it the politicians (sadly of most persuasions) could not push ahead with the expansion of their obsession with the market—something else no-one voted for. In the last few years the public have been generally very happy with the NHS, and this is reflected in opinion polls like the one Lansley tried to suppress. That is all inconvenient , as it destroys the "second –rate" argument. The poor outcomes claimed have been savaged as misleading and selective --- another answer in need of a question , and all the evidence is that the market wastes money , out of necessity. Choice needs spare capacity and a huge bureaucracy.

None of these arguments stand up to scrutiny, but they are all that can be clung to in order to impose the ideology of the Government's aims. That is to end up with an "NHS shell" stuffed full of private companies, like all other public services. A good parallel is the direction some

Councils are heading in---Town Councils on their headed notepaper, but in reality, all services "outsourced" (the euphemism for "privatised") to companies often with politicians on their Boards . Large public institutions represent a lost opportunity for corporate profit so they must go. If Lansley had really spent the last 7 years listening to patients and professionals instead of who he could find to endorse his preconceived ideas, he would be heading in a totally different direction.

It is disingenuous to claim that the founding principles of Nye Bevan's NHS are being preserved. Maybe at present it is free at the point of use , but the comprehensive nature and the universality are soon to disappear with the reforms. But the services remaining free at the point of use may dwindle as rationing kicks in , forcing top-up insurance for full care.

The NHS is a national treasure valued by the vast majority of the population and defines the type of society most want to live in. Patients want it strengthened not fragmented. They want that comprehensive service, the universal coverage and for it to be free at the point of use. They also want and need continuity of care and co-operation amongst their health carers. The last Government and this Coalition have done their best to destroy the latter. It is nonsense and plays into the hands of the enemies of the NHS to claim the Country cannot afford the service. To do so is to admit we have to settle for a two or three tier service where the rich do well and the poor suffer. What those malevolent forces really mean is they don't want the service provided out of taxation. But if the cost to the taxpayer is added to the necessary resulting insurance costs the same financial burden (probably more) results—just look at the USA—who in their right mind would emulate that ? The answer ? Lansley

All the evidence points to the best healthcare arising from co-operation between healthcare professional especially GPs and Consultants, not competition. Competition is of very dubious cost benefit when compared with collaborative models of healthcare. And for one primary care physician to be a patient's advocate and to provide continuity and co-ordination of care—that is what is appreciated by patients. Its importance is recognised by anyone who has had more than a short-term self limiting illness. It is not recognised by a few middle-aged reasonably healthy politicians who just want the odd sildenafil script or we wouldn't hear health secretaries like Alan Johnson saying he doesn't care which GP he sees, or have to tolerate the insistence on "commuter" clinics (taking GPs away from their more needy patients), walk-in clinics or Darzi centres.

A good GP is worth his/her weight in gold to the patient and health service, but this too goes unrecognised. An opportunity was tragically missed a decade ago when Blair started to resource the NHS properly, probably for the first time ever. He should have reduced GP list sizes which would , if implemented properly, have solved the access problem and allowed GPs the time to care for their patients thoroughly. This alone would have reduced referral rates and kept people away from secondary care, allowed better patient pathways to be developed, and saved a lot of money. Instead we had micro-management imposed, anti-GP smear campaigns, a dilution of our role, fragmentation of services and threats that "if you don't do what we tell you , we will find someone who will". Forceful evidence that strong primary care leads to better outcomes was ignored and we suffered the erosion of the GP as the first point of contact.

The co-operation model was sabotaged. I could no longer ring up a well respected consultant colleague, who I have known for years and shared the care of many-a-patient. If he/she felt it appropriate that patient would be slotted into the next clinic. Everyone happy. Try doing that now.

No, what we got were generic referrals going to any Tom, Dick or Harry, vetted by some bureaucrat in a "planned care office" (a misnomer if ever there was one), sometimes rejected, often lost, usually with a wait right up to the "breach" limit if not eligible for the only other category of "2 week—has he got cancer? clinics". All of course through "Choose and Book" because Blair thought seeking a consultant's opinion was the same as booking airline seats—back to

the middle-aged man again wanting to organise the NHS based , it seems ,on only his personal experience. The "opinion" the patient got was often half-baked , came from a "nurse specialist consultant" ,couldn't be followed through so another referral was needed, and left the patient bewildered and angry. Managers think we refer to buildings, not people.

The result of the change in the way health care is provided in England will be the bizarre mixture of patients eventually realising they are inappropriately under investigated and under treated at the GP side of care, but inappropriately over investigated and over treated when they get through the barriers to their private provider. That does nothing to help build confidence between patient and clinician, but will also fuel mistrust between clinicians and in particular between the GP and the specialist. This is nothing compared with the industrial warfare between competing Foundation Trusts that will develop as commercial activities become paramount. I fear for the Consultants working for those organisations, who in many Trusts already are just "workers" and not professionals in the eyes of management. Some Consultants may be attracted to the brave new world outside of the Trusts, and seek to build up patient pathways with Consortia. This may work in some instances, but how secure would this be? I have felt increasingly sorry for my hospital colleagues as they are intimidated and have lost their right to speak publicly, but now it's reaching us as GPs. Consortia are producing long lists of "obligations" and clauses in their constitutions that allow immediate expulsion if a GP espouses view or acts contrary to its aims. As membership is compulsory, this could mean the sack. More "George Orwell" than "Brave New World.

If we abolish this crazy market fetish, like the other UK Countries, we could go back to building patient pathways together without management meddling and with the co-operation, collaboration and continuity of care that otherwise will be driven out by these reforms. Trusts could once again be called hospitals, and Chief Executives and managers called administrators just doing what the clinicians think is in their patient's best interest. Lansley claims he wants to put clinicians in the driving seat, but it is not possible for this to be effective in the poisoned world of dog-eat-dog competition.

So no to commercialisation, competition, fragmentation and micro-management and yes to Consultants and GPs jointly in control with collaboration ,co-operation and continuity of care Come on BMA—fight harder to save the NHS.

PAUL HOBDAY
General Practitioner
Maidstone

'Kill Lansley's bill march and rally 17 May

This was the title of a helpful leaflet from the Met police, welcoming the London 'Save the NHS' demo and hoping we would have a safe day. And that set the tone-colourful, friendly and peaceful.[1] We assembled outside University College Hospital and marched through central London, past Trafalgar Square and finished with a rally outside the Department of Health in Whitehall. There were at least two thousand people [2], many from NHS, medical groups and Trade Unions. There were a few of us from the NHSCA and our banner was seen by many.

But what did the march achieve? As we walked, the throng of commuters and theatre goers got the message about how serious the situation was, and the demo was reported by BBC London news. But I could not find coverage in national media such as the Guardian. Did Lansley listen?

DAVID LAWRENCE
Consultant in Public Health

http://www.youtube.com/watch?v=PhyYli1sReE&feature=related

http://jwarren.co.uk/photos/protest/save-the-nhs

http://www.youtube.com/watch?v=Sxt0drDVkk8

http://righttowork.org.uk/2011/05/pictures-from-the-kill-lansleys-bill-march/

The National Picture

On April 4th Andrew Lansley, the Secretary of State for Health, announced "a pause, a two month 'listening exercise', in implementing the unpopular Health and Social Care Bill. He said he would listen to what people had to say about the Bill, which he is pushing through Parliament, in the 'natural pause' before the Bill goes to the Lords.

The Bill aims to turn the NHS in England from a largely publicly provided monopoly service into an open competitive market, such that any private profit -making company could bid to provide NHS care; the " any willing provider" policy.

It would turn the NHS into a huge public- private partnership, in which big corporations would mint money out of safe government contracts, along the lines of the £70bn PFI hospital building programme.

The Bill would hand 80% of NHS money to new commissioners, with which to purchase hospital and community care in England. There would be a new NHS commissioning board and GP commissioning consortiums.

Many soon realised that these consortiums would end up being run by private commercial companies, with GPs only nominally in charge, giving these companies a further opportunity to milk the NHS for profits for shareholders.

Lansley was forced to announce this 'listening pause' because of the enormous opposition to the bill, from trade unions, and professional organisations. Eventually Labour's Ed Miliband called for junking the bill, and even the Liberal Democratic party, part of the coalition government, developed major criticisms.

The British Medical Association, the main doctors' union, organised a Special Representative Meeting (SRM) on the 15th March to discuss it and representatives voted for the bill to be withdrawn, although the leadership pushed through motions supporting GP commissioning. Unison has said that the bill should be scrapped. Unite, which contains the Medical Practitioners union, is opposed to the bill in its entirety. The nurses at the RCN conference in April were so hostile to the cuts and the Bill that Lansley did not dare address the conference. They took a 98.7% vote of no confidence in his handling of the Health Bill.

The Royal College of General Practitioners (RCGP) expressed concern that GPs would face an impossible conflict of interest as they would be contracted to provide primary care for patients, at the same time as commissioning hospital and community care while being forced to cut the NHS budget.

The Parliamentary Health Select Committee and the Public Accounts Committee were sceptical that the Bill's reforms could be successfully implemented at the same time as making £20bn of 'efficiency savings,' which they thought were the main issue.

This is why Lansley set up a special group, the NHS Futures Forum, to appear to take stock and consider criticisms.

The "red lines"

However, both he and Prime Minister Cameron made it clear, that there were red lines which would not be crossed. Cameron said he would not go back on GP commissioning consortiums, the independent commissioning board to oversee them, every hospital becoming a foundation trust (FT), payment by results tariffs and the abolition of primary care trusts (PCTs) by 2013. In other words, there would only be minor tweaks to the bill.

After all, on 20th February, Cameron announced that in future, the government would not bother with separate bills to privatise different services like the Royal Mail and the NHS. He said there should be a presumption that public services must be open to delivery by private companies.

He would bring out a white paper that would give an automatic right for private bodies to bid for public work. The Telegraph commented that these changes could ultimately see many functions of the NHS - from operations to walk-in triage – being run by private firms.

He need not have worried. The NHS Futures Forum set up by Lansley contains ardent supporters of privatisation measures, led by chairman Steven Field. It was Dr Field, former chairman of the RCGP, who publicly urged the BMA not to totally oppose the health bill at their SRM. The Forum therefore is a cosmetic exercise.

On 4th May Cameron announced the setting up of a separate group of health policy experts, to advise him on how to manoeuvre the health Bill through Parliament. The group includes leading lights who assisted Tony Blair in implementing Labour's stepwise privatisation of the NHS; former NHS Chief Executives Lord Nigel Crisp and Sir Ian Carruthers, Bill Moyes former chairman of Monitor, Mark Britnell former Department of Health director of commissioning and now Head of Health for management consultants KPMG and Nicolaus Henke, head of global health systems at McKinsey.

Number ten's new health policy advisor, Paul Gape, trained by McKinsey, set up the group.

Meanwhile the real job of axing the NHS and physically breaking it up is proceeding apace. In fact it is accelerating.

David Nicholson, Chief Executive of the NHS and chairman of the NHS Commissioning Board, (even before the Bill has been enacted), wrote to Strategic Health authorities (SHAs), primary care trusts (PCTs) and pathfinder consortia leads on 13th April and told them to implement its provisions.

As the PCTs are being dismantled and making staff redundant, they are simultaneously

i. setting up the GP commissioning consortiums as "shadow pathfinders'
ii. implementing the £20bn "efficiency savings" and cutting the money to the hospitals
iii. increasingly putting NHS services out to tender to private companies. These include services such as ambulance transport, path labs, community hospitals, walk- in centres and more private finance initiative (PFI) new build hospitals.

David Nicholson has a track record in the NHS as a hatchet man. He won his spurs in the 1980's closing down the mental hospitals in the era of Mrs Thatcher. He was chairman of the West Midlands SHA at the time that Mid Staffordshire hospital was cutting nurses and medical staff to save £10m, to become a foundation trust. Cynthia Bower, chairman of the Care Quality Commission, testified to the public enquiry last month, that the Mid Staffs disaster happened on his watch.

He is an ardent supporter of the Foundation trust (FT) business model and is pushing through the requirement that every NHS trust becomes a FT by April 2013.

Nicholson told the BBC in February that if hospitals do not reach the bar of financial surplus set by Monitor, then hospitals must merge, be rundown or be taken over by private companies.

The employers' organisation, the NHS Federation, was more frank in January, saying that hospitals would have to close as result of the reforms in the health bill. They said that allowing GPs to commission services from 'any willing provider' could mean the closure of some hospitals and units in order to make way for new private providers.

That demolition job has already begun under Nicholson's diktats at the Department of Health. PCTs are being grouped into larger administrative groups called clusters. These clusters are instructed to implement the £20bn cuts. These are euphemistically called QUIPP efficiency savings (Quality Innovation Productivity and Prevention) or CIPs (Cost Improvement Programmes) but they are straight cuts to staff, beds, departments and whole hospitals.

The PCT clusters, these interim commissioners, are decommissioning services on a massive scale.

Throughout the country, they have drawn up lists of operations and procedures that can no longer be performed by their hospitals. Depending on post code, this can be anything from hip and knee replacements, to inguinal hernia repairs, to operations for carpal tunnel syndrome or trigger finger, hysterectomies for bleeding, IVF treatment etc.

The hospitals depend on the PCTs commissioning money in order to function. Without this funding, they cannot provide care to patients. Waiting lists are starting to lengthen. Emergency patients, of course, still keep coming. But the DH has ordained that hospitals will not be fully reimbursed for their care if the number of emergency admissions via A&E exceeds last year's figure. Also, patients who are re- admitted within 30 days of discharge will not be paid for, which is expected to deprive NHS hospitals of £790m of funding.

The so called " pause" is designed to hide the fact that the biggest ever destruction of hospital care is taking place in the UK, coupled with the biggest ever outsourcing of clinical care to the private sector in England.

ANNA ATHOW

Clinical Activity in the English and Scottish NHS Before and After Devolution

In the last two decades of the 20th century, growth in clinical activity in the NHS hospital sector was broadly equal in Scotland and England. Scottish inpatient and day case hospitalisation rates increased by an average of 3.7% p.a. between 1980-81 and 1998-99, while English rates increased by 2.9% p.a. between 1985-86 and 1998-99. Scottish new outpatient referral rates increased by 1.8% p.a. between 1980-81 and 1998-99; English rates increased by 2.3% p.a. Over these time periods new A&E attendance rates in Scotland and England increased by 1.1% and 1.3% p.a. respectively.

Similar trend growth in clinical activity came to an end in the 11 year period 1998-99 to 2009-10 after Scottish devolution (Table). In the Scottish NHS, the increase in inpatient and day case hospitalisation rates slowed to 0.6% p.a. between 1998-99 and 2009-10. When the data are expressed as hospital discharges rather than episodes, excluding interspecialty transfers and "episode inflation", the increase fell to 0.07% p.a. or a total rise of 0.8% in 11 years. In contrast, English inpatient and day case hospitalisation rates rose by 2.9% p.a. between 1998-99 and 2009-10. When expressed as admissions rather than FCE's, excluding "FCE inflation", this increase fell to 2.4% p.a.

Trends in new outpatient referrals showed a similarly divergent trend. Scottish hospital referral rates increased by only 0.4% p.a. between 1998-99 and 2009-10 while English rates rose by 6.1% p.a. over this period. Scottish new A&E attendance rates increased by 1.1% p.a. between 1998-99 and 2009-10 compared with an increase of 4.2% p.a. in English rates.

In summary, increases in English inpatient and day case hospitalisation rates were 26 times those in Scotland between 1998-99 and 2009-10. Increases in new outpatient referrals were 13 times greater in England than in Scotland over this period and increases in A&E attendance rates were almost four times greater.

Interpretation of the significance of changes in Scottish trends in clinical activity in the post-devolution decade are easier to interpret than in their English counterparts. Acute admission units and rapid assessment wards were established to deal with emergency admissions and facilitate their rapid discharge. There was also considerable financial investment in waiting list initiatives and increased efforts to facilitate rapid discharge of older patients to community care or supported home care. Collectively, these

initiatives resulted in a decline in winter bed crises and cancelled elective admissions with a progressive fall in inpatient, day case and outpatient waiting times and waiting lists. As noted in a previous newsletter, Office of National Statistics data indicate that Scottish waiting times for a range of elective procedures were shorter than those of England, Wales and Northern Ireland between 2005-10.

At the same time, "bottom-up" demand for emergency and elective hospital admission and new outpatient referrals from the primary care sector levelled off, and A&E self-referral rates also stabilised. These changes were accompanied by abolition of the internal market, rejection of Payment by Results and of further privatisation of clinical services, including the creation of Independent Surgical Treatment Centres. Block grant funding to Scottish Health Boards was retained, based on a needs-assessment formula; perverse incentives to increase hospital income from tariff-based revenue remain absent. Relationships between hospitals remain based on cooperation rather than competition. In 2009-10, only 0.5% of all NHS inpatients and day cases were treated in Scottish private hospitals.

In summary, clinical trend data in the Scottish NHS in the post-devolution decade indicate a steady-state model in which demand and supply are in equilibrium. In the Scottish primary care sector, where 90% of all doctor-patient contacts occur, consultation rates have also remained constant at about three per annum. In 2005, a Commonwealth Fund survey found that within the countries of the UK, Scotland had the highest portion of recipients of NHS care who felt that the care they had received was "excellent" or "very good".

Interpretation of the significance of the much greater increases in clinical activity in the English NHS between 1998-99 and 2009-10 is much less straightforward. Several observations cast doubt on the conclusion that the increases simply represent a response to "bottom-up" demand from the primary care sector to satisfy unmet need.

First, there is a well established relationship between regional morbidity and mortality rates in the UK and hospitalisation rates. These were identified in Scotland in the classic observations of Carstairs & Morris in 1991. Standardised Mortality Rates (SMR) are a component of needs-based formulae for NHS funding, retained in Scotland in the Arbuthnott formula and abandoned in England for Payment by Results in 2004. Scotland's higher hospitalisation rates prior to devolution were closely related to its higher SMR levels, and partly justified more generous NHS funding than in England. As noted in the table, this relationship was reversed in the post-devolution decade. English inpatient and day case hospitalisation rates rose from 14% below to 7% above Scottish rates between 1998-99 and 2009-10. More remarkably, new outpatient rates rose from 11% below to 42% above Scottish rates, and new A&E rates rose from 3% below to 27% above Scottish rates over this period. This reversal of a long established relationship strongly suggests that rapid expansion of clinical activity in England may not simply represent a response to unmet demand.

Second, the rapid rise in English hospitalisation rates between 1998-99 and 2009-10 is non-linear, with only a modest increase in rates over the five year period 1998-99 to 2003-04, and accelerating expansion over the six year period between 2003-04 and 2009-10. This phenomenon is most evident for trends in inpatient and day case rates and new outpatient rates. The former expanded by only 0.8% p.a. in the five year period 1998-99 to 2003-04 but then increased fourfold to 3.7% p.a. between 2003-04 and 2009-10. Similarly, new outpatient rates increased by 2.2% p.a. between 1998-99 and 2003-04, and then also increased fourfold to 9.3% p.a. between 2003-04 and 2009-10.

Third, while inpatient and day case rates and new outpatient rates increased at broadly similar rates in Scotland and England prior to 1998-99, and in Scotland after devolution, English outpatient rates increased by two and a half times more than inpatient and day case rates between 2003-04 and 2009-10. This implies the referral of increasing

numbers of outpatients with lower degrees of morbidity than previously.

Rapid acceleration of the rise in hospital referrals of inpatient and day cases and of new outpatients from 2004 on was synchronous with a new emphasis on "modernisation", by the Labour administration. This year marked the introduction of Foundation Trusts, and the beginning of the roll-out of Payment by Results in which the greater part of a Hospital Trust's income derives from the volume of patients treated. There was also more emphasis on an increased role for the private sector in the provision of clinical services with the establishment of Independent Surgical Treatment Centres (ISTC's). There is a large body of evidence, principally from the USA, that fee and tariff based health systems amplify hospital activity. If a hospital's survival is critically dependent on patient turnover, in a competitive market powerful perverse incentives exist to drive up its activity. The coincidence of rapidly expanding clinical activity in the English NHS with the introduction of PBR and increasing emphasis on competition and privatisation suggest that the two events are causally related. The way in which these incentives operate is unclear and should now be the subject of detailed enquiry.

In 2009-10, only 1.03% of all inpatients and day cases (173,481 of 16,806,192) were treated in ISTC's and private hospitals. Despite the Labour administration's claims to the contrary, the role of the private sector in the expansion of clinical activity since 2004 has been negligible.

The present review of trends in clinical activity ended in March 2010 before the election of the coalition government. The impact of replacing a real terms increase in funding of about 7% per annum in the previous decade by a small real terms decrease will be severe and is likely to bring the rapid expansion in clinical activity in the English NHS to a shuddering halt.

MATTHEW G DUNNIGAN

Trends in Clinical Activity in the English and Scottish NHS since Scottish Devolution: 1998 - 1999 to 2009 -2010

	England (E)		**Scotland (S)**
	Hospitalisation Rate	**Inpatients[1]/Daycases**	**Hospitalisation Rate**
	per 1000 population	**E/S%**	**per 1000 population**
1998-99	225	86%	262
2009-10	283	107%	264
Change %	+ 26% (2.4% p.a.)		+ 0.8% (0.07% p.a.)
	Referral Rate	**New Outpatients**	**Referral Rate**
	per 1000 population	**E/S%**	**per 1000 population**
1998-99	241	89%	270
2009-10	402	142%	283
Change %	+ 67% (6.1% p.a.)		+ 5.0% (0.4% p.a.)
	Attendance Rate	**New A&E Attendances**	**Attendance Rate**
	per 1000 population	**E/S%**	**per 1000 population**
1998-99	262	97%	269
2009-10	382	127%	301
Change %	+ 46% (4.2% p.a.)		+ 12% (1.1% p.a.)

1. England: admissions to all specialties

   Scotland: discharges from all specialties

Plus Ça Change?

Over 15 years ago a delegation from NHSCA met the then Secretary of State for Health in the Conservative Government. Towards the end of the session, we raised the question of low morale but as there was too little time left for a proper discussion he invited us to put our points in writing. This was done, after wide consultation within the Association.

Whilst in some areas it has been overtaken by events, notably as regards the level of funding, it is perhaps surprising how little has changed.

With rumours abounding that Stephen Dorrell could be Secretary of State again in the event of Andrew Lansley being obliged to fall on his sword, this piece from our archives may have some current relevance.

LOW MORALE IN THE NHS

The causes and some proposals for improvement

A paper prepared by the NHS Consultants' Association at the invitation of the Rt Hon Stephen Dorrell, Secretary of State for Health.

The problem of under funding is of major importance but this has been with us in some form since the inception of the NHS and under various governments. Despite more funds in real terms on a yearly basis our health care system is still run on the cheap compared with most similar countries. It is a tribute to its efficiency that so much has hitherto been achieved despite this disadvantage. It is not unreasonable to regard a greater degree of parity as something towards which the nation should be working, whilst at the same time being vigilant that those funds which are allocated to Health are used in the most efficient manner possible.

We well recall the Secretary of State's caveat that repeal of the 1990 Act was not an answer he could accept. Despite this it has to be said that the great weight of evidence presented to us indicates that features of the Act and what has developed from it are the prime causes of the current low morale in all branches of the medical profession and indeed throughout the NHS.

The roots of Medicine in this country lie in the religious orders and traces of this still remain, for instance in the title of those Ward Sisters who have not been restyled Managers. In the modern world of course we have to be paid professionals and even junior doctors are gradually having their hours reduced to a less monastic level. Nevertheless the element of vocation has been an important one for most health service staff, those in support positions as well as in the various professions. The attitude it produces has sustained the NHS and its staff through many difficult times. In recent years however it appears that more and more of the management and decision making positions are held by those who see their role as primarily to run a business. This is not to denigrate business methods and style in their proper place but to suggest that something intangible but vital is in danger of being lost to the NHS. The awareness of this loss, with the change of ethos which accompanies it, has made a large contribution to the unprecedented departure of medical and nursing staff at this time. We believe that many, after years of trying to preserve professional standards, have concluded that nothing they say is being heard and give up trying. They just keep their heads down and do their jobs, while exploring the route to early retirement. Such a posture of defeat is deeply unsatisfying and the next stage is to vote with the feet.

More detailed examples of the types of frustration being encountered often relate to the fragmentation of the service, replacing loyalty to the humanitarian concept of the NHS with corporate loyalty to an individual unit, with the encouragement of destructive rivalries and antagonisms, lack of openness and interference with rational strategic planning.

The short-term and resource-consuming annual process of the contracting round is a major source of dissatisfaction. The pricing system is patently arbitrary, at the mercy of creative accounting and produces clinical absurdities which bring the system into disrepute. Total fairness could only be achieved by having centrally imposed and rigidly monitored rules on what must be included in a price and far more detailed measurement of actual costs. The resource implications of this are frightening, and its benefits highly dubious.

Clinicians do not like operating a two tier system, favouring patients from one geographical area against another because of the vagaries of the contracts, or even more so, giving priority to those patients whose GP happens to be a fundholder. Such two tier systems are now openly acknowledged and clinicians obliged to operate them, either through managerial diktat or because they are persuaded that not to do so imperils the survival of the unit. The ethical conflicts involved are morale sapping.

Surgeons have problems with the waiting list rules and initiatives. In particular, arbitrary rules about length of time on waiting lists lead to absurd distortions, when a hernia may outrank an urgent cancer treatment. Waiting lists are also being misleadingly manipulated by inserting long delays for patients wanting a surgical outpatient opinion.

Perhaps the most potent influence is the awareness that there is often not the time, the facilities or the backup to provide the quality of service that we know is right. The responsibility for such shortcomings has been delegated down to hospital level as in the oft heard phrases "that is a matter for individual Trusts" and "this information is no longer held centrally".

A situation where all the hospital disciplines are under pressure, understaffed and under-resourced leads inevitably to loss of the smooth cooperative working relationships and climate of trust which are essential for patient care and safety. Nerves are frayed and tempers are lost, followed by embarrassment and remorse, or lasting bitterness.

In contrast to this shortfall in the direct services to patients, we see all about us public money being lavished on areas of lesser importance.

It is not in dispute that the number (and remuneration levels) of managers in the NHS has risen dramatically. Some but by no means all of this may have been justified but there can be no justification for the explosion in the use of external management consultants to report on every problem which occurs. So often these costly reports are discarded, or worse, acted upon and then recognised to have been flawed with all the ensuing damage to working relationships.

Since 1990 Health Authorities and Trusts have invested heavily in newsletters and public relations departments designed to present their policies in the most favourable light. Not surprisingly this is resented by professionals who have seen their avenues of representation and expression closed.

There is another growth industry in management courses and conferences, run by commercial organisations at an average of 200 to 300 pounds per delegate day. Someone is doing well out of the NHS Reforms.

There are areas where management and health professionals are working harmoniously together but too many where they are not. So much of the current system seems designed to set them against each other by having incompatible priorities and covert performance criteria. Saints might make it work but not enough of them have been appointed.

We are in no doubt that the NHS is being privatised. This may not be in accord with either the public statements or the personal wishes of the Secretary of State but is happening nevertheless by a creeping growth for which the market system provides the perfect culture medium.

The extension of the Private Finance Initiative to clinical services and the proposal that Trusts could run their own private insurance schemes are but two recent examples.

In many health districts the implementation of speculative bed-cutting policies has necessitated the habitual placing of contracts for routine and waiting list operations with private hospitals. In such cases the market has been manipulated deliberately to expand the private sector, usually without any comparative evaluation of costs.

What then can be done to raise morale?
Many of our respondents make the point that nothing less than the abolition of the commercial market will suffice, that it is incompatible with the principles of the NHS and that it is impossible for both of them to survive.

That is the view of this Association but we have tried in the following section to make suggestions for moves in the short term which would be of significant benefit to morale and might reduce the alarming loss of staff which is threatening patient care and safety.

1. Government should publicly (and repeatedly) affirm the view that public service is no less worthwhile than manufacturing or commerce.
2. In all health care systems, professional cooperation has been shown to be superior to financial competition. Government should acknowledge this.
3. National pay bargaining should be restored for all groups which prefer it. This would release clinical and managerial time and avoid the divisiveness of differential rates for the same work between and within units.
4. Managers should be instructed to be open and honest about the shortcomings as well as the successes of their units. The concept of Performance Related Pay for managers should be re-examined, and if it is to continue, the criteria and payments should be in the public domain. The decisions should be made not at local level but on the recommendations of the main commissioning body. As much weight should be given to statistics on patient care eg hours spent in A and E waiting for a bed, numbers of patients nursed in the "wrong" ward etc as to budget balancing.
5. Plain English should become the official means of communication with heavy penalties - such as rejection until rewritten - for all pretentious and lengthy documents written in "management speak".
6. Unnecessary and alien business terms such as Purchaser, Provider, Business Plan and anything which includes the word Corporate should be dropped.
7. Management consultants should not be employed without the prior sanction of the Audit Commission.
8. A new clause in the Patients Charter should give all patients the right to be treated in a ward of the appropriate specialty, with careful monitoring of any failures to meet this standard. This would need the resources to allow realistic occupancy levels.
9. Whilst waiting times are important, surgeons should no longer be obliged to defer patients with greater clinical urgency in order to avoid embarrassing (to the management) failures to meet targets.
10. There should be a thorough audit of information collected - what it is for and whether it is meaningful. Much of it is not, like the departmental insistence that new outpatients and return visits are lumped together. No information should be collected unless it can be demonstrated to be accurate and of practical value.
11. There should be a similar audit of the amount and value of the clinical time spent on non clinical work. It is not cost effective to involve clinicians in the minutiae of management and budgets.
12. There should be a removal of the capping of local authorities to enable inadequacies and delays in Community Care to be tackled.
13. Morale should be seen as an important factor, to be monitored regularly for the attention of Government.

NHSCA
May 1996

The AGM and Conference 2011

as announced in the March Newsletter,
the event will be held this year on

Saturday 1st October at Bedern Hall, York

The furore in England over the Health & Social Care Bill is reflected in the majority of the articles appearing in this edition of the Newsletter.

As all the indications are that this is likely to be continuing unabated until the end of the year, the Executive Committee has decided that the main part of the Conference will be devoted to considering how we can best continue our efforts to have the Bill withdrawn, not merely amended.

Key speakers will lead discussions how we can influence the different target groups.

For the same reason, although we would normally be due to hold the meeting in Scotland, it seems imperative that we meet again in England this time, a decision which had the support of our Scottish representatives..

By choosing York, almost equidistant between London and Edinburgh and a venue which has proved popular in the past, we hope that many of our colleagues working in Scotland will be able to join us.

Their input and that of colleagues from Wales will be particularly helpful as we anticipate having with us Dr Peter Samuel to talk about the work featured elsewhere in this edition.

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