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# NHSCA

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**EDITORIAL September 2010**

## THE BIG ISSUES

In this newsletter, I am delighted to have contributions by Julian Nettel, recently retired Chief executive, with his reflections on the NHS after 35 years; Richard Thompson our new PRCP, as well as by Mark Aitken, Andrea Franks, Clive Peedell and Anna Athow.

We have a new government. Surprise, surprise we are in for yet another reorganisation. This was outlined in the White Paper 'Equity and excellence: Liberating the NHS' published in July 2010. This further radical shake up of the NHS did not feature in the election manifesto and took even those in the know by surprise. On one thing there is general agreement: the NHS has been thrown into turmoil. Mr. Lansley has identified the cause of the supposed malfunction of the NHS in poor commissioning by PCTs. By transferring nearly all the commissioning to GPs whom he considers have a monopoly of wisdom and knowledge in this field, efficiency saving will be made. Thus there will be an independent commissioning board with GPs rather than PCTs taking on the bulk of commissioning through a network of up to 500 new consortia while strategic health authorities will become smaller outposts of the commissioning board. As before there seems almost no role for specialists, those who have the expert knowledge, in commissioning. The 150 PCTs will lose most of their commissioning role except possibly for specialist services. Their responsibilities for local health improvement will transfer to local authorities who will employ the Director of Public Health jointly appointed with the new Public Health Service. How these hundreds of consortia will work better needing more staff on much less money is unclear. It has been estimated the costs of making these changes will be £2-3bn. It seems likely that this new policy will lead to further fragmentation of the NHS, with a further loss of an integrated approach. It seems likely that the new plan will set GPs against consultants with the GPs having the upper hand. This could lead a serious deterioration in the standard of specialist services. GPs could also face an ethical dilemma as they will be directly responsible for budgets as well as for treating individual patients. A patient could be left wondering whether a doctor's decision is the result of his/ her need or of how much money is left in the budget. Is a treatment recommended the cheapest or the best?

Those hospitals, about half, which are not yet foundation trusts will be pushed into doing so often having to meet almost impossible financial targets. Competition will be further promoted by requiring community nursing and

other parts of the provider arms of PCTs to become independent. Following Labour's initiative staff will be encouraged to form social enterprises with patients being able to choose from any willing provider. The regulators will undergo a huge shake up, Monitor, in addition to its role in supervising foundation trusts is set to become responsible for promoting competition, licensing health care operators, managing market entry and exit and probably setting prices for NHS treatment.

Kieran Walshe Professor of Health policy at Manchester Business School said 'the Tories had repeatedly dismissed the prospect of radical reforms to the NHS before the election. This however is the biggest reorganisation since 1974. Apart from existing foundation trusts there is very little of the existing architecture which will be left unchanged. This is a massive structural upheaval and it looks very expensive, and very risky to do it quickly.'

Chris Ham chief executive of the Kings Fund health care think tank said 'there is a real risk that people will be distracted and preoccupied with this huge organisational change just at the point where they need to be increasingly focused on productivity and efficiency'.

Sir Richard Sykes who resigned as chairman of NHS London within a week of having their plans overturned, interviewed on the BBC's World At One said that GPs did not have the skills needed for commissioning.

Thus the policy of promoting competition will continue and be enhanced.

This policy goes back to 1989 when spurred on by obvious problems in the provision of health care, the Conservative government with health minister Kenneth Clark introduced the concept of the market into the NHS with the purchase provider split at its heart. This concept has had eloquent champions like Professors Julian Le Grand and Professor Alan Maynard. The government has listened to these 'experts' rather than the profession who are deemed to be self interested and self satisfied and in need of the stimulus of competition to make them work more effectively. Professor Le Grand has indicated that the market reforms have been a success as apparently evidenced by an increase in NHS productivity. He compares the English with the Scottish NHS where productivity is lower. However the figures from Scotland are disputed and will likely be shown to be false.

Advocates of the market assume that the NHS is inefficient and that competition is a useful mechanism to challenge this inefficiency which is sometimes manifested by hospital failures in the deliver of care and variations in the standards of primary and secondary care. They see

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competition as a way of creating uncertainty and challenging complacency of providers. I once heard Paul Corrigan, a most influential health advisor to both Messrs Blair and Brown, say in an after dinner speech at the RCP that 'our job is make your lives uncomfortable'. This epitomises the attitude of some of these advocates of the market.

Those of us working at the coal face have experienced a different reality. The internal market with the purchaser provider split is wasteful and divisive. The whole process of negotiating contracts for services in the market is hugely costly. The market sets different parts of the NHS against each other and leads to a fragmented approach rather than encouraging people to work together for the welfare of patients.

We now have the benefit of a detailed and comprehensive report on Commissioning carried out by the House of Commons Health Select Committee<sup>1</sup> This is particularly damning on costs 'Whatever the benefits of the purchaser provider split it has led to an increase in transaction costs ,notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on these transaction costs. The suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the DH were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency should be addressed immediately. A thorough review of the commissioning process was reported. The deficiencies of this process were highlighted and explanations found for the poor performance of the commissioning process. eg lack of knowledge and skill in the PCTs.

In the conclusions of this extensive report, one option considered was to abolish PCTs and reintroduce health authorities, ie replace the quasi market and abolish the purchase provider split. The examples of both Wales and New Zealand are quoted but strangely not that of Scotland which has successfully abolished the market.

A number of witnesses to the enquiry argued that 'we have had the disadvantages of an adversarial system without as yet seeing many benefits from the purchaser provider split. If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon after 20 years of costly failure the purchaser provider split may need to be abolished'.

We would strongly endorse these conclusions. Indeed this lies at the heart of what the NHSCA stands for.

In a letter to the Times Alan Cameron Consultant Surgeon commented on the Times's idea that Sir Terry Leahy who is stepping down from Tesco might take charge of the NHS. He pointed out that in buying a can of beans one could have the choice of several shops and that competition might drive down price. In contrast on being

admitted as an emergency most would just like excellent treatment rather than a choice of providers. Independent providers have performed some elective surgery but they have cherry-picked the quick and easier cases leaving the more difficult and expensive ones to the NHS.

We have been greatly heartened that the BMA has finally taken up this fight and is vigorously campaigning against the market.

By getting rid of this wasteful market approach, as has been successfully done in Scotland, and also by ridding the NHS of the armies of management consultant, millions could be re-directed to direct patient care, disease prevention programmes and hospital building. A return to a system in which healthcare is planned for a given population would ensure an integrated approach, restore professionalism, pride and satisfaction in working in the NHS which have all been diminished by the market approach, so inappropriate for healthcare.

Finally in this time when large savings are needed in public spending, getting rid of this wasteful market approach in the NHS would deliver huge saving without compromising patient care.

Another serious problem which is seriously affecting delivery of care in hospitals is the European Working Time Directive (EWTD). This was fully implemented in August 2009 so that doctors should work a maximum of 48 hours per week. This is covered in Mark Aitken's article. The reduction in hours has resulted in the working of shifts. Multiple hand-overs of patients occur. Many consultants involved in general on take complain of lack of continuity and that they are only ones who now know about the patients on post take rounds (that is if any juniors are present). At the same time the BMA junior doctors committee clamours that there is insufficient time for training which must be done in the specified hours. These obvious problems have been highlighted in numerous articles in the medical and lay press. One of the main objectives of the EWTD presumably was to improve the welfare of doctors in training. However as Mark Aitken points out a recent survey report in Clinical Medicine the journal of the Royal College of Physicians by McIntyre et al<sup>2</sup> showed that compared with a similar period before implementation of EWTD there was a notable increase in episodes of sick leave among junior doctors. The report on the working of EWTD, commissioned by Alan Johnson when he was health minister, undertaken by Sir John Temple has recently been completed. He reported that trainees suffered from being poorly supervised and that their chances of learning during the day were reduced because they had to fill gaps in rotas. He said that some of the older consultants were reluctant to work later hours preferring to stick to standard week. One might ask when people get older why should they not? As might be expected from Sir John the solution is to re-organise the working of consultants with greater emphasis on consultant delivered care. The discovery of penicillin did not need a controlled trial to

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show that it worked. Equally the effects of EWTD on continuity of care and on training are plain for all to see. Juniors do not get sufficient experience in 48 hours per week. Their attendance at specialist clinics is also radically reduced with serious effects on specialist training and experience. Everyone knows that the only way one can learn medicine or surgery is to do it, albeit with the right supervision and back up. It is frightening to think that present day juniors may have to learn to take decisions on emergencies or in specialist clinics for the first time when they are consultants. Medicine used to be fun and rewarding. Doctors enjoyed working in teams. The shift system has destroyed all this. Most consultants now doing on take find it a burden and cannot wait to stop. They find that they alone maintain continuity of care. This cannot be healthy. This obsession with consultants doing all the work also means that their specialist work will also suffer. It cannot make sense for the consultants especially as they get older to be working harder than the juniors. This is Alice in Wonderland. We need to disabuse people like Sir John Temple and others of the 'great and the good', far removed from clinical work, of the notion that juniors are

there mainly for training. If so, for what are they getting paid so well? Furthermore, if the EWTD applies to juniors surely it also applies to consultants. There needs to be an equitable division of work with sufficient hours worked by juniors both to gain the necessary experience and provide a decent standard of care. I hope that the Royal Colleges will stand together to support their fellows and members and insist that our government tell the European Commission that the EWTD does not work in UK and should be modified, especially as it appears that many European countries pay it only lip service.

ROBERT ELKELES

Guest Editor

### References

1. House of Commons Health Committee (2010) Commissioning. Fourth Report of Session 2009-2010
2. McIntyre HF, Winfield S Te HS, Crook D. Implementation of the European Working Time Directive in an NHS trust: impact on patient care and junior doctor welfare. *Clinical Medicine* 2010 10 134-137

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# MARKET FAILURE alive and well in the English NHS

## Introduction

The 1989 White Paper, "Working for Patients" was a defining moment for the NHS, because it resulted in legislation -The NHS Community Care Act of 1990, that introduced a healthcare market into the NHS with the purchaser-provider split. It was also the first time in NHS history that the medical profession (BMA) and other health care professions were excluded from the policy making process. The health policy academic, Professor Rudolph Klein, called this "the end of the double bed" and the BMA has not been involved in NHS policy making ever since.

The last 20 years has seen the purchaser-provider market remain in place in various forms, undergoing numerous transformations, which have resulted in great turmoil for the NHS and its staff. Despite major failings, the market is alive and well in the English NHS and is about to get another shot in the arm with the new White Paper, "Equity and Excellence: Liberating the NHS". If implemented in full, these radical changes could see the end of the NHS as we know it, decimating its founding principles. It is therefore of prime importance to understand why market based healthcare is such a threat to the NHS.

This article discusses why markets fail in healthcare with practical examples, and goes on to explain the underlying powerful ideology that continues to promote a market based healthcare system despite all its failings.

## Market failure in theory

The essence of a market system is that "free agents" try to maximise their own "utility" or wellbeing, by comparing market prices for goods and services (commodities) with what they are worth to them. Provided prices are free to move, prices will adjust to the forces of supply and demand. This system is driven by self interest and competition, and relies on information symmetry between buyers and sellers. This allows price signals to enable the market to wring the most out of an economic situation.

In a healthcare market, the illnesses and diseases of patients, and their treatments and investigations are the commodities that are traded. Thus illness and diseases and their investigations and treatments have a market value.

Kenneth Arrow's seminal paper in 1963 identified that healthcare is inherently subject to market failure. This was actually very well summarised by Gordon Brown, of all people, in a speech to the Social Market Foundation in 2003, before he went on to ramp up the NHS market!

The following list summarises the many different types of market failure in healthcare

1. Patients are not sovereign - there is information asymmetry. In other words, the providers of care (doctors) know more than the receivers of care (patients). In the same mould there is asymmetry of information between

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GP and PCT commissioners (purchasers) and secondary care (providers).

2. Accurate information is extremely difficult to collect and interpret. Measuring quality of life, effects of comorbidities, and the need to look at longer term outcomes are 3 of many examples.

3. Healthcare is difficult to commodify e.g thousands of procedures require coding.

4. Use of healthcare is unpredictable and leads to pooling of risks e.g a visit to ITU costs hundreds of thousands of pounds. Thus price signals don't work.

5. There is a risk of supplier induced demand e.g hospitals have incentives to over-investigate and over-treat.

6. Contracts are hard to write, are expensive and need to be short term to allow entry and exit to the market. Huge administrative/transaction costs.

8. Exit is very difficult in a universal system ie Hospital closures are a political hot potato.

9. Excess capacity is needed for choice to work i.e a plurality of providers.

10. Insurance systems will give the cheapest and best coverage to the well, and the most expensive and least coverage to the sick.

11. Inverse Care Law. (Those who need healthcare least use the services more, and more effectively, than those with the greatest need).

12. Doctors i.e professionals, are by their very nature anti-market. Doctors control access to the healthcare market e.g GPs want to refer patients to their local hospital.

13. The first duty of private companies is to their shareholders, not patients.

14. Markets respond to people's wants more than needs. Patients/citizens become consumers increasing demands on the system. This is a particular problem in a single payer (tax funded) system.

15. There is a need for clusters of specialties. Economies of scale. High volume workload needed for quality.

## Market failure in practice

### 1. USA

We have to look no further than the \$2.3 trillion dollar United States healthcare system to see market failure in practice. There are 50 million people uninsured and up to 100million underinsured. The system places a huge cost burden on employers and is recognised as a major reason for poor competitiveness of major companies like General Motors. In the US, 62% of all personal bankruptcies (900,000/year) are due to medical expenses and 78% had "insurance" policies! It is estimated that 30% of the total healthcare budgets is due to transaction costs of the market. This is probably not surprising when looking at the 2009 remuneration of various HMO CEOs:

#### Humana

Current CEO: Michael.B.Mccallister

Compensation 2009: \$5 million per year and \$50 million stock options

#### UnitedHealth

CEO: Stephen J Helmsley

Compensation \$3 million and stock options worth \$660 million

n.b previous CEO, **Bill McGuire** involved in \$1.5 billion stock options scandal

#### Aetna

CEO: Ronald A Williams

Compensation 2009: \$24 million and stock options worth \$170 million

n.b Former Aetna CEO John Rowe earned \$175 million in 65 months (\$225,000 per day!!)

Healthcare fraud is also a multimillion dollar industry.

Despite the huge cost of the US system, they have poorer outcomes for life expectancy and infant/maternal mortality rates compared to healthcare systems. Allyson Pollock has described this system as "islands of excellence in a sea of misery".

### 2. UK

The first indictment of market failure is that it seems to be well understood! Hence we don't even have a proper market system in the UK. It is a "quasi-market" because prices are fixed under the tariff system. In addition, there has been recognition of the need for oversight of the market using various expensive Quangos including Monitor, the Competition and Co-operation panel, the Reconfiguration Panel and the Care Quality Commission.

Thatcher's purchaser provider split (1989) has been well critiqued in the literature and the recent Health Select Committee report on Commissioning was even more damning of the current purchaser provider split, suggesting that "after 20 years of costly failure" it may need to be abolished if it didn't improve. The HSC report stated that research commissioned by the DH, but not published by it, estimated the costs of the P-P split to be as high as 14% of total NHS costs and after several changes and reorganizations since 1989, how many chances does it need?

The HSC has also reported on the problems and expense of ISTCs and the PFI.

In addition, since information is crucial to the proper functioning of the market, we cannot forget the £20 billion NPfIT disaster and the current issues with Summary Care Records. These projects are being pushed because they are vital to the market functioning properly. Patients/consumers need access to information to make choices in a market with a plurality of providers. The complexity of measuring healthcare outcomes and then publishing them for public consumption is only going to make this worse.

Even the pro-market thinktank, Civitas, concluded in a recent report that improvements in the NHS were "not attributable to the market" and that the NHS was taking on extra costs "without realising the benefits" of the private sector.

### 3. The Medical Profession

One of the less talked about aspects of market failure in healthcare is that fact the markets are intrinsically anti-professional and vice versa. Doctors control access to the healthcare market. This becomes a fundamental problem to the proper functioning of a market if GPs only refer to their local hospital. It seems that Professor David Marquand was right when he said that public service professionals "...are in a profound sense not just non-market, but anti-market".

Professor Julian le Grand's famous "Knights and Knaves" analogy in his books *Motivation Agency and Public Policy* and *The Other Invisible Hand*, explains how the "trust" (professional) model of delivering healthcare is problematic and best solved by using a market model, where the user (e.g patient) is "Queen". Interestingly, Le Grand has admitted that in order for patient choice to work well, patients need "choice advisors". I thought that GPs were choice advisors!

- A lot of this thinking comes from Public Choice Theory, which uses complex mathematical economic theory to reject the public service ethos and professionalism. Paradoxically, this view of medical professionals as "rent-seeking, knavish" self interested agents of business, feeds on itself. In the United States, where the commercialisation of medicine exists in its most extreme form, the American medical profession has lost public support faster than any other professional group. (Blendon R. JAMA 1989)

The attack on the medical profession over the last several years is consistent with the demands of the market, which favours entrepreneurial doctors over more "traditional" doctors who value the social contract. This is also reflected in medical training, where there is significant evidence that MMC was politically engineered to produce a flexible, "fit for purpose" medical workforce to facilitate NHS market-based reforms:

*"...most importantly, (MMC) will deliver a modern training scheme and career structure that will allow clinical professionals to support real patient choice"* (DH Website)

An editorial in the British Journal of General Practice described how the proposals for the establishment of the Medical Education Standards Board (which later became PMETB):

*".... are clearly intended to enable the Secretary of State of the day to direct that standards can be lowered to meet the manpower demands of the NHS"*

### Why markets in healthcare?

So if market failure is such a problem in healthcare, then why have market systems been actively promoted across the entire public sector and across the world? In a word – "Neoliberalism".

The deregulation of the global financial marketplace has eroded the sovereignty of nation states. This is well summed up by the following statement by Tony Blair in 2004 speech in Chicago:

**'Every day about \$1 trillion moves across the foreign exchanges, most of it in London. Any government that thinks it can go it alone is wrong. If the markets**

**don't like your polices, they will punish you.'**

Since London was at the epicentre of all this trade, New Labour had to heed the demands of the financial markets, which are based in neoliberal orthodoxy, which is summarised as follows

1. Deregulation of trade and finance. Independence of Central Banks.
2. Low taxation, especially corporate tax. The best way to achieve this is through lower public spending i.e "Rolling back the state" - sell off public services and privatise them, reduce pension burden.
3. Low inflation (price stability, "integrity of money") i.e wage control through the defeat of the unions.
4. Increasing investment opportunities – PFI, privatisation of essential services, PPPs.
5. Citizen-Consumerism (hence patients become consumers – "patient choice").
6. New Public Management i.e run all public services along business lines.
7. The use of Social Capital e.g Third sector social enterprises.

Hence, Peter Mandelson famously said: "We are all Thatcherites, now" (Peter Mandelson, *The Guardian* 2001)

This is why we have seen market ideology penetrate through to public services all across the world and particularly in England. Thus the prominent Labour MPs John Denham and Roy Hattersley (respectively) stated :

*"All public services have to be based on a diversity of independent providers who compete for business in a market governed by Consumer choice. All across Whitehall, any policy option now has to be dressed up as "choice", "diversity", and "contestability". These are the hallmarks of the "new model public service" (John Denham, the Chartist, 2006)*

*"The commodification of public space has now become an aggressive Blairite objective"* (Roy Hattersley, quoted in the *Guardian*, 7th November 2005).

### Conclusion

In summary, it is a sorry mistake to continue down the line of market based healthcare. It will damage the medical profession, destroy the NHS and most importantly result in greater inequalities of patient care. Unfortunately, the Tory-Lib coalition are going to take this a lot further than New Labour with the new White Paper. This policy, like many other of the coalition domestic policies like "free schools", is based around the neoliberal doctrine. In an ironic twist, this ideology has been recognised by none other than Ed Balls, the architect of New Labour's neoliberal policies in his election statement for the New Labour leadership contest:

*"This is a new neo-liberalism for the 21st century – a merger of Thatcherite neo-Conservatism and Orange Book Liberals, which believes that getting the state out of the way is the road to a stronger economy and fairer society."*

We should heed the words of the Nobel Prize winner in

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Economics, Joseph Stiglitz, who said:

*"Neo-liberal market fundamentalism was always a political doctrine serving certain interests. It was never supported by economic theory. Nor, it should now be clear, is it supported by historical experience. Learning this lesson may be the silver lining in the cloud now hanging over the global economy."*

So far, I don't think the message has got through to the profession about the dangers of the White Paper. We somehow need to galvanise a wave of opposition to these proposals. We shouldn't accept the White paper as a fait accompli and need to recognise that Andrew Lansley has a very shaky democratic mandate to push it through. As Professor Kieran Walshe noted in his recent BMJ editorial, the Coalition Government stated there was an agreement to "stop the top-down reorganisations of the NHS that have got in the way of patient care." (ref: HM Government. The coalition: our programme for government. Cabinet Office, 2010). In addition most of the proposals were not in the Tory election manifesto. This has also been picked up by the Lib Dem MP Andrew George, of the Health Select Committee, who said that Lansley had "Torn up the agreement to resist imposing a top-down re-organisation".

Let the fight begin!

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Further reading and references:

Arrow K (1963) Uncertainty and the welfare economics of medical care. *American Economic Review* 53: 941-73

Brown G (2004) *A Modern Agenda for Prosperity and Social Reform*. London: Social Market Foundation

I recommend an article in the *New Statesman* by two Labour MPs, Jon Cruddas and Jon Trickett, which nicely summarises the direction that New Labour took:

<http://www.newstatesman.com/uk-politics/2007/12/tories-party-labour-jon-turn>

The former Australian Prime Minister, Kevin Rudd, also recently wrote an 8,000 word polemic about neoliberalism, which is well worth a read <http://www.themonthly.com.au/monthly-essays-kevin-rudd-global-financial-crisis--1421>

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## WHAT WE CAN ALL DO

As I move into the historic office of the President, I am wondering how I can push forward a fresh agenda for the Royal College of Physicians. What would my 119 previous distinguished holders of this office, glaring down at me from the walls around the building in Regent's Park, have thought and done? I am confident that they would have first pointed to our quincentennial mantra of improving medical standards. How can we do this?

Doctors are sometimes criticised unjustly for their resilience to change. This is a misconception. Most will embrace changes that are based on clear and positive evidence. Think how rapidly clinical practice now changes year on year in every specialty; many of our prescriptions and procedures of only a few years ago are already out of date. If you do not believe me, read the BNF for 2000! Numerous organisational changes have been prescribed for the NHS with little evidence behind them except dogma, sometimes leading to disaster, and often eventually a U-turn. Need I mention MMC, MTAS, EWTD, personal budgets, Care in the Community, world class commissioning, and PBR? Indeed, it seems that the NHS is once more to be reorganised by returning to group GP commissioning and, although there may or may not be

merit in this proposal, weary staff will nevertheless see this as yet another permutation, to be followed inevitably by reorganizational fatigue. Because of these changes, most hospital staff feel frustration leading to the despair, and then the apathy that now stalks the corridors of those without power. Working with patients day-by-day, they believe that standards of care, or "quality of care" to use the current buzz cliché, have fallen. This is at least partly due to the changes on which the staff were never honestly consulted, and any comments ignored. We have no time in our practice to step back from this and, unfortunately for our patients, we put up with things and make do to keep the service at least running. Anecdotal evidence is not quantitative, but it becomes convincing if it is consistent, and my College hears consistent narratives.

I am not simply looking backwards. I want instead to suggest that going forwards through their Colleges, the medical workforce, doctors and nurses, must demand that the efficiency of care is transformed, and insist that its quality be improved. We are all unseen traffic managers when we get into a car, full of useful ideas about how Boris Johnson might so easily save money and improve the efficiency of our roads. This untapped talent should be

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constantly applied to the Health Service, by the medical and nursing staff getting together, thinking about everything their hospital does, and then suggesting and pushing through ideas for change. We are guilty of descending without sufficient protest into tolerating poor standards in hospitals through inexorable indifference and tunnel vision. We ignore blatant shortcomings around us, and concentrate instead on our narrow clinical duties. Don't we put up with long waiting times in clinics, inefficiently booked clinics, poor clinical practice, dirt, waiting around in theatres, wasteful prescribing, long waiting lists etc- all types of preventable waste. Do we find out how the system works and why it is failing? Furthermore, our attitude changes if a family member or friend is unwell. They must be seen quickly and get the best available care; not for them any delays or cancellations! Or, like others, they go private, and we grudgingly accept that the Service in which we work cannot offer the same timeliness, cleanliness and service that we know should really be our constant aim.

So, can the hospital medical staff change this and become a concerted force for improvement? Yes, we can, as another President said. The Secretary of State announced that he wishes to shift power towards clinicians and patients. This could be our opportunity. I propose that all hospital doctors group actively together into what were once called 'cog-wheel' committees – physicians, surgeons, pathologists, etc., and take hold of the local agenda primarily to improve quality, but also to save money ('efficiency savings'). Everyone working in the NHS, and many patients, have ideas about how to save money. The larger cross-speciality medical staff committees, strengthened by high rates of attendance, can be a powerful force to direct change. A cohesive group of medical staff is unstoppable; but it must be united, and should take the nursing staff with it. Never forget that tenacious staff committees can force chief executives to leave!

Returning to the observation of things that are failing, why do we ignore so much around us, and close our eyes to the sight of common bad practices, such as patchy communication with general practitioners? Should we not constantly be bringing matters large and small to the notice of junior and senior managers? The medical press has recently and correctly highlighted the plight of whistleblowers, courageous doctors and nurses whose careers have been amputated following well-intentioned and seemingly accurate complaints. We are all nervous, if not frightened, of sticking our necks out, because of the fear of insidious retribution and victimisation. Consequently, there has grown up a culture of secrecy and cover-up. Do we, for instance, advertise and learn from mistakes and near misses? Not often enough.

How can our profession, which, surprisingly to me, is still thought by the public 'to run' hospitals, change this? First, I suggest by channelling concerns through the inclusive 'cog-wheel' committees, so that no individual is then exposed and revenged. Secondly, by encouraging,

again through the committees, a universal and continuous critical approach to everything around the hospital, from maintenance and cleanliness, to queues and poor care, and sharing and comparing this with your colleagues. Thirdly, if any member of staff is criticised for doing this, he or she should be determinedly and vigorously defended and supported by colleagues, who should prevent any unnecessary suspension. Fourthly, our College is thinking how it could be a discreet safe haven for complaints, to be passed back confidentially and anonymously to medical directors and chief executives. Finally, the Department of Health must be much stronger in supporting whistleblowers, limiting suspensions, and changing the culture among Trusts, so that they welcome and encourage complaints as a force for improvement, and properly investigate them. It has been said that a reporting structure and a blame culture cannot co-exist.

I further suggest that every Trust should encourage comments and complaints from staff as well as from patients, and record the outcomes of these openly and with satisfaction. Monitor and SHAs should ask Trusts in their annual reports for more of them, not fewer. They are the badges of an active and improving culture, not shameful things to be hidden in carefully worded publicity, and only exposed by calling on the Freedom of Information Act. Organisations should ask for more comments and include them in individual or service appraisals. Staff, services and Trusts without enough comments should be told at each annual appraisal to make sure that more genuine ones are presented in the next year. This culture of constructive criticism should spill out into clinical quality, so that we all constantly look to improve the standards of our care. It is a form of audit. Do we share our views with colleagues in our own specialty? Often not. Do we suggest that another specialty in our hospital is badly performing? I doubt it.

This amounts to a substantial change in attitude and actions; some will see it as harking back to an era when doctors ruled, but they will be wrong. Dare I mention here the important forum of a well attended senior staff dining room? But I believe that, led by all the Colleges, the medical and nursing professions can improve the quality and efficiency of the clinical service, education and training, and restore the high morale that is essential to any successful organisation. We can promote professionalism within hospitals. I shall try hard to achieve some of this, but I do not underestimate the difficulties, and the Royal College of Physicians will need the active support and collaboration of its Members and Fellows, and all the other Colleges and Faculties. A call to arms!

Will YOU join with your local colleagues and change things? Your patients and your Trust need you to do so.

SIR RICHARD THOMPSON

President Elect Royal College of Physicians

July 2010 ( President from July 27th)

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# TRUST US WE ARE DOCTORS

It is easy to criticise, particularly when we may have failed repeatedly to stop those running the service from sending our train in the wrong direction, but surely enough is enough. The last few decades have seen the transfer of influence away from those with medical knowledge and training to a faceless bureaucracy. It is as if we have been benignly supervising a junior doctor carrying out a clinical procedure when we suddenly realise that, unless we take over, the patient will be harmed. We need to call a truce with the bureaucracy, give them the guidance which will put our train back on track and obtain meaningful assurances that the remedial work will be carried out.

There are so many areas where we have been unable or unwilling to stop the bureaucratic sledgehammer from beating clinical commonsense into submission that it is difficult to know where to start. In the first instance we need to see how we have been cuckolded. Thereafter we need to enunciate the measures necessary to undo the harm imposed by successive administrations and reflect upon our own morality and mortality.

## How we lost control

Prior to the enactment of the NHS doctors were the main representatives on the boards of the voluntary hospitals. They ensured that medical priorities were acted upon with due diligence and that the necessary funds were raised to address these issues. These items included such things as setting up a Radiology Department; building a Paediatric Ward; establishing a blood transfusion service; etc. In this respect many voluntary hospitals acted ahead of national initiatives and for this their hospitals received generous support from the local population.

After 1948 it became the responsibility of the Government not only to lead the process of modernisation of what had become the NHS but also to finance it. Thereafter, the involvement of locally practising doctors in deciding how these changes should be brought about has been slowly and methodically eroded.

Even as late as the 1970's Consultant staff had a meaningful voice on their Medical Advisory Committee and the doctors from the various specialties elected their own Chairmen to sit on the Medical Executive Committee. With the creation of Hospital Trusts and latterly Foundation Hospital Trusts these medical representatives were no longer elected by their peers but *selected and radicalised* by higher management. Today the only elected chairman in our local Foundation Hospital Trust is the chairman of the Medical Advisory Committee and he *does not* have a place on the Management Board. In that situation how can those with medical training and experience influence the direction in which our train is running?

Somewhere along the line we appear to have become untrustworthy. "Don't let a doctor drive the train. You can't trust him".

## The Meaning of Trust

The English language like all languages is a means of communication. Over time words take on alternative nuances. "Trust" is a good example. In the doctor patient relationship the patient might be expected to assume, "I rely upon you to do what is best for me", and in today's environment, "but if you betray my trust I will sue you". Whereas with the current consultant contract our employer, the Hospital Trust, openly declares "We rely upon you to do what is best for the Trust", and in small print, "but if you betray that trust we have the right to sack you". The bottom line for the patient is their wellbeing. The bottom line for the Hospital Trust is their bank balance. Herein lies the conflict. This is not solved by saying, "the money follows the patient" because the *going rate* is decided not by an *itemised bill* but by an *average rate* relating to the diagnosis. Factoring in co-morbidities, which might influence the clinical strategy, is not part of the game plan. Perhaps our role with management should be reversed, as it was prior to 1948. In that way the Management Executive would be appointed by the Consultant Body and the tenure of these executive posts would depend on individual performance. But would the politicians trust the doctors not to feather their own nests by bending the rules in much the same way that MPs exploited their expenses allowance? Mutual distrust seems to have been the basis on which healthcare politics has evolved. Ever since we accepted the very generous terms of remuneration negotiated between 1946 and 1948 (and thereafter) there has been a nagging impression that we were more interested in the money than the principles of caring for the underprivileged sick.

## Changing the mould

Fragmentation of the NHS has resulted from the same process used by industry to introduce cost-effectiveness. Outsourcing activities which do not require your expertise cuts costs. That is fine where a factory merely assembles parts manufactured elsewhere. A hospital is far more complicated. The attempt to downsize hospital Emergency Departments by the introduction of NHS Direct and local drop in centres was the last straw. A sick patient or a worried relative can not know the risk they are taking by using this alternative service, and advice given without access to specific technology or the nearness of expert help is cavalier. Even if 90% of



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patients attending a hospital Emergency Department have trivial problems at least the other 10% have a better chance of a successful outcome. Did our profession really recommend these initiatives to the Department of Health?

What about the other impediments foisted upon us by the bureaucrats?

I will take the European Working Time Directive (EWTD) and the A&E waiting time target as examples.

### The EWTD

The EWTD was formulated to deliver social justice and protect employees from employers demanding excessively long hours of work. The Labour Government sought to implement this directive to all walks of life without thinking through the detrimental effect this might have when delivering healthcare in our hospitals. The over-riding objective was the delivery of quality and safety but they failed to set up an evidence based assessment that would support this directive. The premise was founded upon a handful of complaints where harm was seen to have been done to hospital inpatients and where the defendant had used the excuse of excessively long continuous hours of work as their main defence.

The Royal Colleges argued that a 56 hour working week for junior doctors was a reasonable compromise but the introduction of a maximum 48 hour working week would adversely affect junior doctor training and in the long run would seriously affect their ability to judge clinical situations through lack of personal experience gained from following the progress and outcome of individual patients.

In early 2009 a parliamentary debate, initiated by Andrew Lansley (the shadow Secretary of State for Health), failed to get any change in the law. The large labour majority and the intransigent attitude of Alan Johnson (the Secretary of State for Health), who came away beaming all over his smug face for having upheld their policy of more stick and less carrot for the medical profession, derailed the motion. Alan Johnson claimed that any junior doctor could legitimately sign up to working more hours than their colleagues. We knew that our juniors would not ostracise themselves by agreeing to such exceptional working conditions. The result was the fragmentation of team structure and loss of personal identity. Emergency rotas became filled by clock-watching operatives who were no more motivated than workers in a bucket factory.

For the politicians to win this argument they would have to demonstrate a significant improvement in patient care, but how would they measure this outcome? The crudest measurable parameter would be mortality. Suffering could be assessed by morbidity but this would have to rely upon complaints. Fortunately for the politically driven manager, complaints can be massaged up or down because the grey areas between

serious, trivial and unfounded complaints are as wide as the grey areas between serious, trivial and unfounded injuries resulting from road traffic accidents.

The recent paper in *Clinical Medicine*<sup>1</sup> should prick the consciences of those Labour MPs who voted with Alan Johnson against making an exception to the EWTD for junior hospital doctors. This study showed that there was no significant reduction in emergency patient mortality but a highly significant increase in absence from work due to "sickness" amongst junior doctors. The likely adverse long-term effects of the latter will not be seen until these doctors attain consultant status, when the predictable effects of lack of continuity of learning will come home to roost and degrade the quality of care to patients<sup>2,3</sup>.

If Andrew Lansley, the new Secretary of State for Health, is a man of principle then, armed with this evidence that was lacking in 2009 and the Government's parliamentary majority, he should oversee the derogation of the EWTD for hospital doctors.

### The four hour A&E waiting time target

The idea that any patient should have to wait on a trolley in A&E for an appreciable time let alone more than four hours is abhorrent. For those of us who have had to lie on a trolley for any length of time we would support any initiative that shortened that uncomfortable experience. Unfortunately the four hour waiting time is applied to all A&E/Emergency Department attendees whether their medical problem is serious or trivial. A doctor's decisions must be based on clinical priorities not bureaucratic targets. Our hospital Managers have learned how to coerce the A&E nurses and, when that fails, how to manipulate the data so that the 98% target is achieved. This is despicable but true.

One might assume that the principle behind the four hour waiting time target was imposed in order to identify and remedy deficient resources. These critical resources are:

- adequate numbers and seniority of staff at the point of entry
- appropriately located and staffed investigational support
- adequate numbers of co-located beds where patients can be nursed whilst a clinical management plan is being formulated.

Most of us will have experienced examples of poor decision making resulting from the need to comply with targets. Unfortunately most of these cases are hidden from view in order to preserve the myth that every emergency patient receives best practice.

I would like to take this opportunity to illustrate the way in which the four hour target creates situations

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which hinder the delivery of best practice by referring to two specific clinical experiences:

1. A patient, inappropriately discharged home from A&E, and whose subsequent complaint failed to change the mould.
2. A patient transferred to an inappropriate hospital location prior to collapsing and dying. No relatives. No complaint. No lessons learnt.

Neither of these situations would have arisen without the threat of the waiting time target being breached and a consequent drubbing for the A&E nurses.

1. A 60 year old woman slipped and fell on a concrete path at her home. This resulted in pain and difficulty in moving her left knee. She crawled to her telephone and after some discussion an ambulance was called. She arrived in A&E and was assisted to a chair in the waiting room. Time passed. Her leg became increasingly painful. Other patients came and went. Eventually she was sent for an x-ray and after a long wait was told by a junior doctor that there was no fracture and she could go home. She was wheeled back to the waiting room and offered some paracetamol. More time passed. Finally a nurse anxiously explained that the 4 hour deadline was approaching, and with the help of an assistant she was taken out of A&E and bundled into a friend's car. Her injury made it impossible for her to care for herself and in due course she agreed to be admitted to a private hospital until she was independent. Luckily she had some private health insurance. A relative was so enraged with the poor NHS care that she photographed the injured leg which now revealed very extensive bruising. Many weeks later she attended the Orthopaedic Clinic at the same NHS hospital. The doctor seemed surprised at what had happened and capped that by pointing out an undisplaced fracture at the lower end of her femur. Her written complaint received a perfunctory reply "from" the Chief Executive who failed to enunciate how processes would be changed in order to prevent a similar occurrence.

2. An 80 year old man was brought to A&E by ambulance. He was complaining of abdominal pain. He had an ECG and a blood test. A provisional diagnosis of acute coronary syndrome was made. Within a short time arrangements had been made to send him 40 miles up the A12 to a cardiothoracic centre for stenting. In the interim he was transferred 100 yards down the corridor to a temporary ward which was about to be demolished. Unfortunately, somewhere on this journey, he collapsed and was rushed back to A&E where he subsequently died. There was no post mortem. If we assume that the provisional diagnosis and planned

transfer to another hospital was correct, then trundling him down a long corridor to a non-cardiac area was foolhardy. In point of fact the diagnosis might well have been incorrect and the outcome inevitable but that is no excuse for shunting the patient out of a safe clinical area just because of the threat of breaching the four hour A&E waiting time target. Interestingly, eight weeks on, the hospital IT system showed the patient to have died at the cardiothoracic centre and thereby any audit of what really had happened had been effectively avoided!

An outside observer might easily put these adverse outcomes down to poor clinical practice and fail to appreciate the ticking clock that encourages hasty decisions. You might argue that the medical staff can't be blamed for these outcomes because the decisions to move patients are made by nursing staff who in turn are trying to avoid getting the stick from their managers.

Either way it is the imposition of targets by bureaucrats who lack clinical skills that unsettles clinical staff. Some members of staff may take a little longer than others to make appropriate decisions. Rattling the cage with a stopwatch in one hand is counterproductive.

### **Putting our own house in order**

Assuming that the new administration will heed our concerns about the unsatisfactory way in which healthcare is being delivered, will we just go back to the way in which we practised several decades ago or will we take on board the initiatives that previous administrations tried to implement. Subsequently will we make the necessary changes to our work schedules so that real improvements in healthcare can be enjoyed by our patients?

These changes should include:

- Avoiding multitasking activities when "on call".
- Keeping ourselves in the Emergency Department when "on call".
- Leading the Junior Doctors in the Emergency Department rather than following them.
- Organising the rotas so that continuity of care is the norm and not, as at present, the exception.

### **Who should oversee the delivery of local services?**

Can you trust NHS doctors to challenge Management when profitability is out-trumping clinical priorities? How were Mid-Staffordshire, Basildon and many other Hospital Trusts enabled to let down their patients? It is all too easy for us to hide behind the apron strings of the Trust Board and like the three wise monkeys to claim ignorance. Surely the way forward is for Government to

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legislate to change the management structure including the role of Monitor and the Strategic Health Authorities. In the future the composition of higher management in Hospital Trusts should be **predominantly populated** by medically qualified non-executive directors (NEDs). The main drawback might be the risk of encouraging the politically motivated empire-building practising consultant to jump on the bandwagon for personal gain. This could be avoided by changing the appointment criteria for non-executive directors (NEDs) so that:

- NEDs should be retired hospital consultants.

You might wonder why senior hospital doctors would wish to exchange a few years of their cherished retirement for a trivial salary in order to act as guardians of the local NHS services. It might be the prospect of having to be subjected to the vagaries of the local emergency services when personal health problems become critical. It might be the wish to reserve favourable consideration on arriving at the pearly gates. The charitable acts of some of the industrial entrepreneurs of the nineteenth century, whose fortunes had been made off the backs of the disenfranchised masses, may have been motivated in order to solve the riddle of the camel and the eye of the needle.

### Conclusion

Where do we start and where will this end? First we must regain control of the NHS charabanc before it careers over the precipice. Decisions need to be made

jointly between central government and the profession. The politicians can define the budget and then we will decide how that money should be spent. Rationalise our multitasking hierarchic culture. Comprehensively derogate the EWTd. Change targets into aspirations. Reverse the ethos that took most GPs away from the out-of-hours service. Close NHS Direct and drop in centres and enhance the hospital Emergency Departments. We need to define and accept responsibility for resource management (rationing) and redefine the role of private practice in our health economy. Above all else we must regain the trust of the public.

MARK AITKEN  
Consultant Physician

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## THE AGM AND CONFERENCE 2010

**Saturday 9<sup>th</sup> October**  
**Bedern Hall, YORK**

Details and application forms for this event were sent  
to members on August 19<sup>th</sup>.

If any have gone astray further copies can be obtained from the NHSCA Office

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# THE WHITE PAPER ON THE NHS

This has been the major talking point since our last Newsletter and several of the articles, including the Editorial, in this issue relate directly to it. It is sure to be the major item of discussion at the forthcoming AGM, held immediately after the Party conferences and as Parliament is reassembling.

On the Parliamentary front, an NHSCA delegation is meeting Lord Howe, Conservative Health Minister on 1st September and we are seeking a meeting with the Liberal Democrat Health Minister, Paul Burstow.

The following letter was sent to each of the original six candidates for the leadership of the Labour Party but none has replied.

7th June 2010

Dear

*In view of your candidacy for the leadership of the Labour Party, I am writing to you on behalf of the Executive Committee of the NHS Consultants' Association, an organization whose main purpose is the maintenance and development of the NHS as a public service, true to its original principles.*

*We have noted with interest that, in the inevitable period of reappraisal, candidates have expressed doubts about some actions of the previous government.*

*In the light of this and in relation to the NHS, would you personally be willing to reconsider the policy of continuing and indeed reinforcing the market based system introduced by the Conservative government twenty years ago? This has particular relevance now with the recent report on Commissioning by the Health Select Committee and the call for major "efficiency savings" in the NHS.*

*Together with the BMA and other organizations we have been working on developing positive and more cost effective alternatives to "the Market" in the NHS in England.*

*We would welcome the opportunity to share our ideas with you.*

*With best wishes,*

*Peter Fisher  
President*

At the August meeting of the Executive Committee it was decided that we should try to coordinate our efforts with those of KONP, the NHS Support Federation and other like-minded bodies.

Much of the public debate so far has been raised by those working, in various capacities, in the NHS and it was recognized that informing the general public of what the White paper proposals mean for them is of great importance.

A draft set of points to be put to the public (as below) was agreed, with the addition that a "tabloid version" was also needed and this is being commissioned. It was decided to seek the views of organizations representing the public such as LINKS and the Patients Association and they are being invited to give support in principle to the draft.

## Arguments for the public

*1. You are being promised right of referral to any hospital or named consultant as if it was something new.*

*Prior to the imposition of the market system in 1990 you could be referred in this way to anywhere in the NHS but that right ceased with the introduction of commissioning in which contracts were made with particular hospitals and "patients followed the contract". Rights of referral were further obstructed by the introduction of referral management systems which could refuse GP referrals or direct them to some other hospital or consultant.*

*2. Despite government claims, this right will not necessarily be restored because as well as acting for the individual patient, your GP will be obliged, whether he/she wishes it or not, to have a role as commissioner, making contracts with hospitals which may conflict with where you prefer to go.*

*3. Acting as commissioner will leave your GP less time to give to patients.*

*The only alternative will be to employ someone else to do this work, which may well be a private company having an interest in private treatment centres or hospitals.*

*4. Allowing private providers to compete with the NHS, "to increase choice", brings the system under EU rules. These state that no preference can be given to NHS facilities, including your local hospital. Any GP consortium which does so could be open to legal challenge. This makes it more likely that your local hospital could see its services reduced.*

*5. Instead of having the patient's interest as the only concern, GPs will in future have to watch their commissioning budgets, so there may be a conflict of interest when considering a referral. If you wish to go to a hospital other than the one with which your GP has a contract, it may cost more from the commissioning budget. This could*

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*mean pressure on your GP about where to make referrals (as there has been under PCT commissioning)*

*6. All hospitals are to become Foundation Trusts, competing with each other and the private sector. Thus they will be obliged to try to attract patients from outside the area and concentrate on their most profitable lines.*

*7. The idea of a hospital seeing its prime responsibility as providing a service for its local population will be a thing of the past.*

*8. The real question is **not** about whether commissioning should be transferred to GPs instead of Primary Care Trusts.*

*It is commissioning itself which should go. The Health Select Committee recently concluded that commissioning was still a problem after 20 years of trying to make it work.*

*To continue with this expensive, divisive and inefficient system at a time when the NHS is under financial pressure is perverse and means diverting scarce resources from frontline services.*

*It should be replaced by a system of planning in which GPs, hospital staff and representatives of the public work together to design integrated services in the best interest of patients.*

Some positive responses have already been received.

PETER FISHER

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## REFLECTIONS OF A RECENTLY RETIRED CHIEF EXECUTIVE

I forget exactly when it was in 1975, but it was rather late on in my final year at university when my philosophy tutor quite unexpectedly asked me what I intended to do by way of a career and suggested I looked at the NHS. Having decided to give up on the idea of becoming a journalist I applied for the NHS graduate training scheme and joined the service later that year.

From that time to last year I was able to construct an entire career in London hospitals, first as a junior administrator (my first job title was rather splendid – assistant house governor) later as a general manager and latterly, for fifteen years, as a chief executive. I realise now that I am something of a dinosaur; there are very few who make a career of running hospitals that span generations, but it gives me a perspective on what has happened to the Service over the same sort of period that many doctors experience throughout their careers. I have a mixture of rather odd, conflicting and in some ways contradictory feelings about what has happened to the NHS over this time. I suppose this is because although there has been extraordinary change at many levels, the fundamental process and business of the health service has remained the same; namely the central relationship between the patient, the doctor and the clinical team and its resultant care and treatment. In many respects all that has happened in the NHS has been the constant attempt to organise itself better so as to optimise this relationship, wherever it might take place. I guess that is all I have tried to do for much of my 35 years in the service as well.

And yet the changes have been enormous. It is easy to forget quite what structural change has taken place just in London's hospital service over the last thirty years. These are the hospitals I have worked in that no longer exist: Westminster, Westminster Children's, St Stephens's, St Marys Harrow Road, The Royal Northern, St James and St Georges Hyde Park Corner. I joined the NHS just as, for the first time, resources were being moved away from London and the south east to more deprived parts of the country. Ever since then I have for every year had savings targets to meet with the constant search for new efficiencies. All right and proper, but after 35 cycles of this I am delighted to be handing over this never ending task to my successors. It will not get any easier.

Other things have changed as well. I vividly remember walking onto a ward in a south London hospital in the late 70s with a senior and much respected surgeon. He stabbed his cigarette out on the ward floor joking that it would test the speed with which it would be cleared up by the domestic staff. I remain ashamed to this day I did not berate him at the time. In some ways this vignette illustrates the changing nature of the relationship between managers and doctors. When I first joined the service functional management and its counterpart, consensus decision making, were the order of the day. Hospital administrators had little authority other than to worry about porters' overtime levels and the complexities of laundry bonus schemes. There was a very strong sense of professionalism which could not and would not be invaded by lay administrators. There

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was no transparency at all in terms of service quality and patients behaved as supplicants, grateful for whatever service was offered. The most important change I have witnessed came in the 1980s. Margaret Thatcher's scepticism and on occasion open disdain for the professions led to a fundamental shift in societal attitude to the Health Service and to the medical profession in particular. This was reflected most powerfully in the NHS through the introduction of the Griffiths reforms and the advent of general management. Suddenly administrators had to become interested in how their organisations worked as a whole and the professions gradually lost much of their autonomy. Ever since then I have seen the service tussle with the tension between professionalism and managerialism. The recent debacle in Mid Staffordshire illustrates well how disastrous it can be when this balance gets out of kilter.

Given the interests of readers of this article, I ought to say something about the 1990 reforms. Looking back, they represent a missed opportunity. It is difficult to view the introduction of the purchaser/provider split and the internal market as anything other than a long drawn-out and extremely expensive mistake. Commissioning, despite the investment in it and the recent World Class Commissioning initiative, has not acted as a major driver of change and improvement. Most of the system changes and advances have either been planned or as a result of responding to the inevitable march of technology, medical research, targets and regulation. The internal market has been curiously impotent. There are many reasons for this but I would highlight the failure to invest in public health medicine and ensure it has proper priority in the hierarchy of medical specialties. If population medicine had been put as the centre of all commissioning decisions, then the picture may have been very different. All this has been a huge frustration to many clinicians and managers. Building on the introduction of general management, the NHS was in a perfect position in 1990 to implement a powerful form of health maintenance organisation (HMO) model with fully integrated organisations bringing together primary, secondary and tertiary services and responding explicitly to the needs of their populations. The government at the time was keen to introduce competition into the system and patient choice between HMOs would have been more problematic in such a system but it would have been possible to some degree, as illustrated by HMO environments in the US. However, as we now know, the loss of patient choice would not have been a serious sacrifice given the paucity of evidence to date that it has had any tangible effect on service quality. It will be fascinating to see how the more integrated Scottish service fares in comparison with the English system over the next few years.

It has been a constant feature of Government policy in England over the last twenty years to invest heavily in the capacity of GPs to drive the system forward. There

are no signs this eagerness to burden them with extensive managerial responsibilities will abate. GPs have been and continue to be expected to fill the roles of clinician, team leader, entrepreneur, strategic planner and commissioner. Some of the financial incentives to encourage them into this wide ranging existence have taken them into at least the edges of serious conflicts of interest. But more importantly than all this, the 1990 reforms drove a damaging wedge between primary and secondary care clinicians when everyone agrees that this relationship is fundamental to excellent patient care. These difficulties are also reflected in what many of my chief executive colleagues regard as central policy confusion at the heart of the NHS. As one of my erstwhile colleagues once remarked, past governments have not known whether to regard the NHS as a company or an industry. This confusion affects everything from the Department of Health's equivocal attitude to foundation trusts' independence to the problems of developing open and trusting relations between neighbouring organisations, unsure as they are whether to collaborate or compete with each other.

Finally some reflections on what makes a good hospital. I was lucky enough to be responsible for St Marys, Paddington for eight years recently. I think we were (and I'm certain it still is) a good hospital. What were the key ingredients to our success? Perhaps the single most important factor was the overriding sense from everyone that they really cared about the success of the organisation. St Marys does seem to attract strong loyalty amongst its staff, and not only those who trained there. Thus personal, professional and corporate loyalties were aligned and not in conflict. This alignment made the key partnership between managers and clinicians so much more productive and relaxed. It also made the task of clinical leadership more attractive. Clinical leaders found they could concentrate on leading their colleagues in a constant search for improvement in patient care and in ensuring clinical teamwork was effective. St Marys also had the reputation of nurturing junior managers and a succession of clever and committed people filled these posts. Consultants found it worthwhile and rewarding to work with their managerial counterparts who were motivated to make life better for both patients and staff. The executive team trusted and respected each other. The other sense we all had was that St Marys housed an important clinical community that was in itself a vibrant clinical network. As a tertiary centre many of its patients had complex combinations of conditions and there was willingness from everyone to collaborate in bringing to bear the very best clinical support and opinion for all its patients. We also benefited from a very well run and sophisticated PCT in Westminster who were supportive of the hospital's work and were themselves keen collaborators in developing more integrated approaches to care. St Marys was also small compared with many teaching hospitals. I suppose I knew on first name terms virtually all the consultant staff. With a budget of just under £400 million and about 270 consultants, my

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view is that it represented about the largest health organisation that can be run with the requisite degree of personal contact between senior managers and clinicians. The current trend towards ever larger trusts, merging in some cases a number of hospitals, makes this vital personal contact very difficult and, dare I say it, this might be one of the reasons why newly merged trusts have been so difficult in the past to become successful, at least in the early years of their existence. Looking forward, there are reasons to be optimistic despite the economic challenges facing the service over the next few years. I say this because I am constantly amazed by the quality and commitment of the young people entering the medical and other caring professions. It was a truly humbling experience sitting on consultant appointment panels in my last two teaching hospital roles meeting spectacularly talented people trying to gain a teaching hospital appointment. Candidates' understanding of the NHS and its organisation, which at one point in the past was uniformly lamentable, has improved significantly and there is now a realisation amongst young doctors that they have leadership responsibilities in their clinical roles and that this demands its own training and personal development. I realise of course that I was in a privileged position in central London, and in other parts of the country life is more difficult, but I'm convinced that the NHS has yet to exploit the latent talent and commitment of its staff to the full. There is hope that the Coalition Government understand this. I write this prior to the publication of the white paper on the NHS. However it is already clear that there is a commitment to localism and moving the NHS onto a new footing where patient outcomes become the litmus

test of service quality, backed up by greater transparency through the availability of information on clinical performance. It seems the policy dilemma over company or industry will be at least partially resolved in the direction of the industry model, with competition being given a real chance to drive improvement. GPs and clinical commissioning are being put centre stage. I just hope the intellectual capital and goodwill that resides within the acute sector is not ignored. Despite the political necessity for competition, the need for health professionals to work together across organisational ramparts has never been more important or necessary. Time will tell if these bold new policies enable the NHS to attain new levels of performance, and whether the Government has the determination to not interfere with the operation of the service when it inevitably hits problems and the financial squeeze begins to hurt.

Looking back, I count myself extraordinarily lucky in being able in all my various roles and organisations to work with innumerable colleagues from every walk of life and background who represent the very best of what the human race has to offer. Despite the complexities and difficulties the NHS constantly invents for itself, it has been a privilege to be engaged in perhaps the noblest of human activities – giving succour and treatment to the sick and vulnerable. I wish my former colleagues and the new generation of clinicians and managers every success in taking the NHS on to its next phase of development.

JULIAN NETTEL  
June 2010

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## DERMATOLOGY AND HEALTH CARE MARKET

Early in 2007 a letter appeared in the Times signed by almost all the UK Dermatologists as well as the Skin Care campaign (representing patient groups) and the Joint Specialty Committee of the Royal College of Physicians. This letter warned of the threat to the specialty resulting from Payment by Results. As a later article in Health Service Journal pointed out “the law of unintended consequences was making itself felt”. These consequences are continuing.

Payment by Results was introduced first for Foundation Trusts from 2004 onwards, then extended to others. Under the fixed national tariff a new dermatology patient would attract the sum of £115 with £59 for a review patient, irrespective of the patient's condition, the treatment required or the complexity of the problem.

By 2007 at least half of the PCTs had started to set up “community” dermatology services and hoped to remove up to 50% of patients from hospital dermatology clinics. This immediately caused concern that a standard tariff payment, if applied to only the 50% of more complicated patients, would not cover the cost of their care. The Chief Executive of a local Foundation Trust has pointed out several times “*if it doesn't pay we don't do it*” and this means that financially non-viable services potentially face closure. By 1997 one unit in London had already closed while most others around the country felt very threatened.

The ‘community’ dermatology clinics across England were ostensibly started to provide more convenient and more local care (‘closer to home’). The overwhelming reason however appears to have been to save money on hospital tariffs and in my own PCT

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one of the initial venues suggested for the “closer to home” clinics was in fact the DGH (several yards away from the hospital clinics) although in the end the site chosen was about a mile away. In some cases other motives were also involved. Merseyside KONP discovered and exposed numerous conflicts of interest in the awarding of contracts to a private company to run private sector “community” dermatology clinics in Liverpool. At this time the company had no consultant to supervise the service and neither of the GPs involved had any significant experience of hospital dermatology although they were to see unselected patients referred by GPs. The regional Dermatology unit, with a full complement of consultants, SpRs and experienced nurses, also bid to run the community service but was initially rejected.

The PCT refused any public consultation when the service was set up and totally failed to keep its promise of a clinical audit of the initial ‘trial’ period before renewing the contract.

The Liverpool GPs were not alone in having insufficient experience. Although supposedly mandatory accreditation was brought in from April 2007, about half of the GPSIs now working in community dermatology clinics around England are still not properly accredited according to DoH guidelines and some have very little relevant training. Many of these services have been found to cost more than hospital dermatology clinics so they are not cost-effective. The GPs working in them are usually paid significantly more than a session of consultant time and in some cases payment for a locum for their GP work is also included. Inevitably some patients, though it is hard to know how many, have to be referred on to the hospital service and so need an additional appointment which must be paid for. In most cases the community clinical records are not accessible to secondary care so it is not easy to discover what has previously been done. From the patients’ point of view there seems to be no point in community clinics which, as well as other problems, often damage continuity of care. It would seem far more satisfactory for the hospital to meet demand by running more clinics, in peripheral sites such as community hospitals if there is a local need, as an integral part of their service. The internal market and Payment by Results prevent any such rational development.

In effect the community services are in competition with the hospital service. They will naturally aim to see mainly the easy patients and of course, with less skilled staff, it is appropriate for them to do so. Many PCTs specify a low follow up-to-new ratio for community services. This however, can mean that patients who should have been followed up are discharged. It also means that when they inevitably do need to be seen again the PCT pays for another new appointment.

Skin disease is common and most medical schools include very little in the undergraduate curriculum. Only a few GP vocational training schemes (including Chester) include a significant amount of dermatology. A tragic unforeseen consequence of the market has been that most English dermatologists are now very reluctant to teach GPs even though most of us enjoy teaching. There is a real risk that any GP with a useful amount of dermatology experience, or a diploma, is likely to be snapped up by a private provider or PCT trying to undercut the hospital service. This discouragement of education is certainly not in patients’ interests but is inevitable under current arrangements.

The pressure to save money by setting up community services has meant that numerous services of very dubious quality have been established. At least one PCT in the North West employs nurses, some of whom have had some training, to see unselected patients referred by their GPs with skin problems. The local consultant was not consulted about this. Similar services have been started by entrepreneurial GPs or private companies. There are anecdotal reports of a minor surgery service in which nurses treat lesions referred by GPs but have inadvertently dealt inappropriately with several malignant melanomas.

In 2008 the Department of Health Improving Outcomes Guidance started a national process of Peer Review for NHS Hospitals dealing with any kind of cancer. For skin cancer this started in 2008-2009. It has been an immensely frustrating, bureaucratic and time consuming process which looks at every aspect of skin cancer care. It has distracted us from other duties and the numerous necessary meetings have taken up clinical time, while the result has been a less convenient and satisfactory service for our patients. I had been under the



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impression that the main reason for this cumbersome scheme was to regulate the dubious 'community' services which the market had encouraged. To my astonishment however, I learnt recently that private sector companies do not have to comply with these measures and are therefore completely unaccountable.

The number of UK dermatologists has always been relatively low compared to other European countries but demand for dermatology services is high and constantly increasing. When "Care closer to Home" was first promoted it seemed that the Department of Health view was that there was no more need for expansion of consultant numbers as most patients would be dealt with in the community by GPs. This view still prevails, and the DOH has persistently refused to expand SpR training numbers. Although it was predicted that 'community' services would remove at least half the hospital dermatology referrals, this has never actually happened and hospital referrals have continued to rise. It seems that that community services have just lowered the threshold and exposed unmet need. As hospital referrals have nowhere decreased as had been intended, further consultant expansion is urgently needed but with no increase of training numbers there are now about 120 vacant Consultant posts around the country. This is a great pity as it is fact a popular specialty and there is great competition for SPR posts.

How does the market affect everyday Dermatology? As with all specialties, finance is a constant concern as the service cannot continue if it does not pay. If the tariff is insufficient to cover costs it will probably be dropped. My hospital leg ulcer service is constantly under threat for this reason. The workings of the internal market are, however, extremely odd. Some common interventions are not covered by tariff at all and this can make a huge difference to financial viability. We do a lot of minor surgery but for several years there was no tariff for this. Although we were doing numerous procedures, the hospital was paid nothing for them except the appointment tariff, in spite of all our attempts to alter this. Eventually the hospital and PCT agreed on a tariff of £500 per procedure, much higher than we had expected. Overnight we became a very profitable specialty and popular with the management. Unfortunately this did not last long and (again overnight) the minor surgery tariff was recently reduced to £144. This includes the cost of the outpatient appointment (currently £ 126.28 for new and £ 66.79 for review)

so the hospital earns more overall if the patient is not given the one stop service we try to provide but is brought back for biopsy another day. Another anomaly is that outpatient surgery by surgical specialties attracts a tariff of £663 per "day case procedure" even if it is the same type of minor surgery for which we receive £140. There seems no way to bring common sense into this. As well as this, if several biopsies are done on the same patient or several lesions removed, only one tariff can be charged. This seems to me like visiting a shop and only having to pay for one of the items in the basket. It is of course possible to bring the unfortunate patients back on a separate occasion for each procedure but is hardly in their interests.

What is the overall effect of the market on Dermatology? It has occupied a great deal of everyone's time worrying about tariffs and discussing how different episodes of care should be coded. Many hospital departments have bid to run community services (rather than allow a private provider) which means that business cases must be prepared, again using up valuable professional and managerial time. Although there was widespread anxiety when PbR was introduced, very few units have actually closed because of resulting financial instability although this remains a threat. A much bigger threat however, is the staffing crisis in combination with mandatory targets which cannot be breached. How much these targets will be relaxed by the new Government is not yet clear. When a consultant leaves and cannot be replaced it becomes impossible to meet the targets and the unit just cannot cope. The remaining consultants are then likely to move to a better-staffed hospital. The unit at Huntingdon has closed for this reason, an additional concern there being that the entire Hinchingbrook Hospital is currently out to tender to the private sector. A number of other units are really struggling and may not survive. Some hospitals are prepared to fill the gap by employing expensive agency locums often from overseas, but others refuse to do so and continue to struggle. In some areas such as Warrington and more recently West Middlesex, PCTs have taken the initiative in decommissioning hospital dermatology services. In the community numerous unaccountable scattered units, often of dubious quality, with no connection with secondary care, remain a serious cause for concern.

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# THE WHITE PAPER

## HOSPITALS

The White Paper says that all NHS Trusts must become Foundation Trusts within three years. There are still quite a few of the eligible 225 NHS trusts that are not yet FTs.

“Our ambition is to create the largest and most vibrant social enterprise sector in the world” Staff will have the opportunity to transform their organisations into employee-led social enterprises.

But Foundation trusts were set up with rules in the 2003 legislation and whether employee-led or not, they have to make a surplus. The White paper makes it clear that they cannot get in debt as “There will be no bail outs.”

They must therefore go to the wall, or be merged, or taken over.

Whereas it used to be the duty of NHS hospital to care for the clinical needs of patient in their catchment areas, this is no longer required of them. In fact if they continue to “over spend” by treating every patient who comes via A&E and outpatients, they will be charged with getting into debt, being financially unviable and eventually labelled as a “Failing trust.”

Monitor has been given the task of deciding what happens to such recalcitrant trusts, and has been given the power to “trigger the a special administration regime.” i.e. the “regime for unsustainable NHS providers” brought in by the last Labour government.

The Coalition is introducing legislation to prevent FTs from reverting to being NHS trusts again. This route is being “de authorised”. Such is the hatred of anything approaching the original aim of the NHS hospitals to fulfil all the clinical needs of patients in a catchment area.

Instead they must be competing autonomous businesses. The White Paper is consulting on:-

- abolishing the FT private patient cap, so that they can make more money that way
- making FT merger easier
- making it easier for FTs to keep any surpluses they raise, so that they resemble more and more a private profit making business.

However, FTs already have the autonomy to partner with private companies, borrow from banks, and sell off their assets (which no longer belong to the NHS) with the approval of Monitor. FTs have to select ‘service lines’ which run at a surplus according to William Moyes, the erstwhile Monitor chairman, and should stop offering services on which they cannot do this. So it’s about reducing service not providing them. FTs are being

gradually forced to ‘cherry pick’ like ISTCs. Intensive care units, for example, are now under great pressure to limit their intakes.

**STAFF** are threatened with loss of national terms and conditions and told that “NHS pensions may act as a barrier to greater plurality of provision.”

**The White Paper claims that FTs will not be privatised.** But FTs ARE being packaged up for this very privatisation. The rules are already being changed, so that the surplus can be extracted away from the NHS as a whole and accumulated within one ‘autonomous’ organisation. The only thing that is missing is the giving of the surplus to shareholders. A small change in the law could tip them over.

**MONITOR’S ROLE** is to be further extended.

- It has to become the economic regulator of a competitive market and moreover it has to promote competition. “Like other sectoral regulators such as OFCOM and OFGEM, Monitor will have concurrent powers with the Office of Fair Trading to apply competition law to prevent anti-competitive behaviour.” P 38.

It must “help open the NHS Social Market up to competition”

It must “require monopoly providers to grant access to their facilities to third parties”

“The focus on competition regulation is on preventing anti-competitive behaviour of powerful suppliers”

These are acts which seeks to actively undermine NHS providers

## THE NHS

Healthcare in the NHS was for 55 years largely provided by a publicly provided monopoly which covered primary, secondary and community care. A large monopoly and the unity of funding and provision, enabled risk pooling and comprehensive care. Sharing assets and transfer from one part of the system to another without transaction costs, minimised expense and maximised patient convenience and professional cooperation. Without these, universal and equitable access is impossible.

These anti-NHS monopoly measures, signal the end of this.

What now becomes paramount is financial survival of ‘autonomous’ providers in a competitive market. “Existing providers will be set free, and will be in charge of their own destiny, without central or regional management or support.” p 46. “Set free” to make money or sink and patients will lose their access to much needed DGHs.

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There will no longer be equality of access, or comprehensive care. For-profit production for the market does not allow this. Massive withdrawal of services is on the order of the day, which is why the new Autonomous NHS Commissioning Board has been given powers “to restrict the scope of service provided by the NHS.”

## PBR

“In order to stimulate this competition,” the payment tool of PBR is being modified.

“Monitor’s role will be to set efficient prices, or maximum prices, for NHS services, in order to promote competition and drive productivity.” P 38.

“We will rapidly accelerate the development of best practice tariffs, introducing an increasing number each year ....” Best Practice tariffs are essentially about driving down the tariff for a procedure, over a period of time. They will advantage those units with least overheads and minimal staffing. They open the door to a race to the bottom on price.

Already the 30% tariff for emergency admissions to hospital, if they exceed last year’s number, has been put into effect.

PBR is being used to prevent provision and downgrade services not enhance and improve them.

## PATIENTS

As for patients, their interests come last. It wants to push ahead with patient budgets so that the responsibility for the risks of care or lack of it, would be borne by the patient. Patients must be encouraged to stay out of hospital and die at home and not be seen in clinic and email instead, in order to save money. Their right to comprehensive services is already being decimated with the withdrawal of lists of operations and treatments by PCTs and withdrawal of accessible hospital care.

## CONCLUSION

This White Paper should be opposed by every means possible as it spells the end of a national publicly provided NHS and putting the corporate private sector in charge of both commissioning and provision.

Already thousands of frontline nursing posts have gone and this will soon involve medical staff as the privateers move in and fragment care, making it harder and harder to defend national terms and conditions and pensions.

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# RESOURCE MANAGEMENT

Managing a limited financial resource is something which all of us tackle in our everyday lives. We make the decisions and allocate those resources in the most advantageous way. What we don’t like is having someone else telling us how communal resources should be allocated, particularly when we consider that we have made a major contribution to those resources via taxation. Healthcare resource management is the polite euphemism for rationing. But this is exactly what we do in our own private lives when resources are limited. When we are sitting across the consultation desk we are uncomfortable about having to be seen as the instigators of rationing. It is a convenient fallback position to be able to explain to the patient that rationing is the axe of the Department of Health and has nothing to do with our perception of what is a reasonable solution to the patient’s healthcare problem. If you are in the blame game then point the finger at NICE or your local Management Executive. Maybe it comes down to the difference between the prolongation of life at any cost and delivering a management plan which addresses the physical and mental distress of having a near end of life problem. Once again, can the patient trust the doctor to formulate the best management

plan for them or their nearest and dearest particularly when those decisions are being manipulated by the non-medical bureaucracy?

Healthcare is full of innumerable grey areas where access to treatment might be deemed inappropriate. How should we manage those who knowingly take recognised risks with their health and then demand treatment for the consequences of their folly? Should screening facilities be an opt-in service rather than an opt-out service? Should we individually have to meet the full cost of drugs such as those used to lower cholesterol or lower blood pressure when they are used for prophylaxis? After all we will willingly pay a premium to insure our house against fire or flood even when those risks are relatively small. Personal responsibilities apply just as much to our health as to our property.

If there is one aspect of hospital care which should be sacrosanct then it is the quality of the nursing, the medical supervision and the inpatient environment, and yet this is the one area which successive administrations have ducked. This should be our first priority and only when these essential functions have been addressed should the range of treatments

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available at that hospital location be bartered on the current regional strategic network. If we can't get the basics right what hope is there for getting the rest into perspective?

### **Private practice**

Dare one mention this word amongst colleagues, particularly those who indulge in this activity? Dwelling on this subject invariably raises hackles. Why shouldn't one choose how many sessions to devote to the NHS and occupy one's remaining time doing other things including private practice? We have got away with multitasking within the NHS so why should we not extend that to include the private sector. Unfortunately, however charitably one looks at this issue one can not escape the conclusion that it will create conflicts of interest. When an emergency arises with one of one's private inpatients will you just give advice over the phone and see the patient only after you have completed your NHS session, or will you immediately hand over your NHS session to

a junior doctor and beetle off to the private establishment without further delay? Who or what commands your priorities? Being the servant of two masters will create conflict. Far better to be wholly employed by the NHS or wholly within the private sector. There will always be patients whose perception of their own health demands the immediate attention that only a private consultation will satisfy. Furthermore there will always be opportunities for NHS managers to offer temporary contracts to those in the private sector in order to fulfil waiting time aspirations or unexpected staff shortages. Patients who would be best managed within the NHS should not be forced down the private alternative because that alternative appears to offer a superior service. NHS consultants are very well paid. Is our NHS image tarnished by the accusation that private practice is akin to moonlighting? Do these private activities lessen the trust of our NHS patients?

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