NHSCA

EDITORIAL September 2011

Time to Put Our Own Houses in Order?

Firstly, it would be appreciated if I may use editorial privilege and say a few words in praise of psychiatry.

Having suffered long and hard as one of them, before retirement, I have long felt that psychiatrists are a misunderstood bunch and that the specialty, now with it's impressive 15 sub-specialties, has come of age, having taken a long time to be recognised for the vital role it plays and should increasingly be playing, in addressing psychological aspects of many medical, surgical, gynaecological and, for that matter, general practitioner concerns.

"Damn the impudence," I hear an older established College Fellow mutter "In my day, these upstarts knew their place. Why, they have even had the nerve to create a Royal College!"

Well, I happen to agree partly with such a sentiment, inasmuch as I believe that achieving Royal College status was not a major, or necessary step towards recognition. But I have more to say about Royal Colleges shortly.

I want to leave the Health Bill and Government deceptions and plans for destruction of the NHS on one side for a moment with Parliament in recess as I write, with my co-editor Robert Elkeles and Sir Richard Thompson keeping you bang up to date with developments and their informed opinions and with Mark Aitken, with his characteristic flamboyance inviting us to take a cynical swipe at key government figures, using ridicule through rhyme as his weapon. He has even provoked yours truly to have a go----!

However, instead of dwelling on this vitally important issue I wish to address a few, mostly rhetorical, questions to those responsible for education and training of our undergraduates and postgraduates, and of our nurses, driven by the suspicion that some of the pressing service problems facing our NHS must partly stem from here. (My long-suffering wife interrupts me at this point having heard it all before). "You're not writing a novel and it's too late for you and your profession to change"—-she is a nurse of the old school and doesn't realise I'm about to involve her profession also in some searching questions.

Is the education of our undergraduate medical and nursing students in safe hands? Have we got the balance right between formal academic training and "hands on" experience and who is checking this out, and for that matter what qualifications and knowledge of the real world do these important teachers have? I am of course excluding the likes of Sir Richard Thompson PRCP and his predecessor Professor Ian Gilmour and Dr Clare Gerada PRCGP as clinically active heads of their respective Colleges with opinions which are well known and respected. Do we need to provide five years basic medical training for all medical students, before the seemingly compulsory specialisation? Do we need to provide our senior nursing staff with a University degree?

More specifically, do we really need to provide extended specialist postgraduate training for all medical disciplines, with a formal assessment or examination, and College status as the necessary requirement to practise?

Yes, I know I am treading on thin ice, but out of more than passing curiosity, I happened to check on the relevant web page defining what the current and proposed requirements are for GP training. The details may surprise and concern you, as much as they do me.

After December 2011 it will be mandatory for GP trainees to pursue a two year foundation programme and a three year specialty training programme. This training and assessment will have three components, namely AKT--an applied knowledge test (multiple choice), CSA----clinical skills assessment with an assessor and a trained role –player as patient and WPBA---a workplace based assessment, covering twelve professional competence areas. The culmination of all this will be the award of MRCGP. The luckier ones applying before the chosen date will be allowed merely to present a portfolio and take an oral examination.

Is this an example of a College tail wagging a reluctant specialist dog?

It all seems a lot to me for a specialty which has contracted down to a five day working week, offering less and less hands-on treatment and requiring it's participants to place more and more reliance on the computer. Haven't I seen this concern expressed before somewhere recently? Well, yes I have! Professor Raymond Tallis, (more later) complains "The exigencies of the computer

screen compete with actual care, distracting health professionals from the needs of their patients"

Incidentally, the RCGP Coat of Arms is based upon a shield derived from St. Bartholomew's Hospital, with black and white patterned areas said to represent day and night—"alluding to the 24 hour commitment of GPs to their patients"

Granted, the Coat of Arms dates from 1961, and it was more appropriate then, but a lot of water has passed under the bridge since, notably since 2004 when a certain BMA GP representative, Hamish Meldrum, tied a certain Government Health Minister, John Reid, into contractual knots. Shouldn't the College now request an up-dated Coat of Arms, with a different shield, you may well ask?

Does all this matter? Well, it surely does if the outcome has been to skew service delivery and lead increasingly to an overtrained, overqualified and potentially understimulated group of colleagues, impacting upon a relatively overworked secondary care service. Ask your local overworked A&E department colleagues how they feel with having to screen and treat a steady trickle of self-referring patients unable to access their GPs out of office hours, (who may have been referred by "NHS Direct" Computer guided nurses as the initial "screen"), and how they feel having to accept for treatment and placement acutely ill nursing home residents also with no out of hours access to their GPs!

This major contractual change in primary care in 2004 should never have been an issue open to negotiation. GP twenty four hour cover, with the perk of independent contractor status for the GP provider was a fundamental plank in the seamless pattern of NHS service agreed from the inception of the NHS. We now have a health jig-saw with a vital service piece missing and likely to remain so.

But what about the other, more well-established Colleges? What are they up to? My limited reading and understanding of their main role from colleagues more involved with day to day hospital politics suggests that they have been longtime obsessed with criticising government- introduced training programmes for post- graduates, summarised under a whole range of acronyms, quite unfamiliar to me, such as MMC, STA, which was replaced by PMETB, not to mention MTAS, described by a previous Newsletter Editor, Professor Ian Gilmour, PRCP, as " the most public and emotive failure—because the Colleges were not involved in it's evolution---and the inherent mismatch between the number of applicants and training posts. How much skilled medical time was wasted on this, and were all the Colleges working constructively as one, and has the problem been resolved? It is not easy for those of us not directly involved to know. One informed colleague advises me that progress has been painfully slow with insufficient attention given to "hands-on" learning and insufficient recognition of the need to provide adequate services beyond the central training hospitals.

Prof. Gilmour hinted strongly at service- implicated lessons to be learned four years ago –"We need a clear view of the nature of the medical work force required to sustain and improve medical care over the next decade or more, with particular regard to technological changes and the shift of some aspects of chronic care into a community setting"— "(Newsletter Editorial Sept. 2007),

Have we moved on since then in knowing what is needed? I suspect not. Do we currently have a Royal Colleges- owned training dog wagging a desperate service- deprived tail? I hope not.

Are we in danger of losing sight of the need to balance priorities, stated simply, between expensive technological advances, which may not provide significant improvements to the quality of life, and provision of acceptable levels of relatively cost-effective care?

Andrew Porter, in his article, warns us of " the danger to quality of life of treating barely viable infants because you can, not because you ought".

And Ruth Marsden, in her thought –provoking article takes a rarely stated hard line in reminding us of the dangers of allowing the public to expect unrestricted expansion of the NHS beyond a "basic service", a suggestion echoed by Cameron Davidson, long-established NHS committed GP, with his belief that "the NHS of the future will not necessarily cover all non-critical procedures."

Allow me to move on to nursing profession issues. I make no apology for widening the discussion to include those who crucially work alongside us and whose training and standards have knock-on effects on our activities.

I have touched upon these in a previous Newsletter article (June 2010.), with Monica Dennis, founder nurse member of the pressure group called "A Dignified Revolution" throwing down the gauntlet to nurse trainers and to the Royal College of Nursing in particular with her title to a lecture given to the "Cure the NHS" launch in Stafford-"Who took the nursing out of nurses? Who is going to put it back?"

Raymond Tallis, Emeritus Professor of Geriatrics, Manchester University and one of our members, responding to yet another report of patient neglect and mismanagement by nurses, touched upon the subject earlier this year in an article in "The Times" headed "More training won't fill a hole in humanity."

He dismisses knee-jerk formal inquiries as " often worse than useless because they prescribe procedural, bureaucratic, legalistic answers to problems that lie elsewhere." He is equally scathing in criticising those who see a solution to gross nursing neglect in more training. "Training in what for God's sake? In things that a four

year old would understand? That older people need to eat and drink? That sitting in a puddle of urine is not pleasant? ---More prolonged exposure, in an extended training course to the rhetoric of "empowering" patients and to educators who have degraded the word "dignity "to an empty mantra will make little difference"

Professor Tallis offers no easy solutions, as he reflects upon the need for genuine soul-searching and reflection ---"on the pressures, the permissions, the attitudes and the priorities that have made mistreating some patients so acceptable."

He stops short of suggesting that the problems facing us are widespread but what if they are and we don't have a sufficient supply of young people coming into nursing with the necessary caring and compassion attributes to meet the needs of an ageing population?

One major obstacle hindering healthy debate about the NHS and it's future is the temptation for everyone to view the issues from self-interested narrow perspectives.

The individual Royal Colleges have their agendas, and are rightly determined to uphold their members standards and rights, but are they working as a cohesive group for the good of the NHS, or do they consider that this a fight for others to take on? And if so, who, one may ask.

New life may have been breathed into the sleeping dinosaur that is the BMA by our brave Council members actions and challenges, but it will always have a prime function to represent it's divergent member groups interests, even though given recognition by Government as the negotiating voice of the profession.

And how do we ensure the voice of the public is heard and respected through those such as NALM and local LINk groups ,who may have token Government blessing but have limited independence, shackled, if the Government has it's way, to a CQC, which itself needs scrutiny, and tied financially to local authority apron-strings.

Our relatively tiny organisation, the NHSCA, (joined with the Fed and KONP of course), is a refreshingly free and honest broker for the NHS and as our hard working President keeps reminding me, whenever I start to lose faith, continues to punch well above it's weight and will no doubt continue to do so as it resumes battle with government over crucial stages in the Health Bill proposals.

But please let's not forget that there are other issues beyond those of Government, and within our own backyard, involving the future of our NHS, as highlighted by myself and others in this Newsletter which merit discussion. Let's open them up for debate.

GEOFFREY MITCHELL
Guest Co-Editor

Healthcare is not a Business

At the time of writing the coalition has completed its 'listening phase' following the introduction of Andrew Lansley's bill to re-organise the NHS. The NHS Future Forum has met and pronounced. A revised bill is being processed seemingly at alarming speed.

As these changes are being debated, the NHS has been told to find £20 billion in efficiency saving over the next four years that is 4% per year which has not been achieved in any health system (The Nicholson challenge first articulated by Sir David Nicholson the NHS chief executive). Aside from these savings, at least 17 NHS hospital trusts are so short of money that they will need to impose deep cuts in services if they are to survive. Local communities could lose their A&E departments and maternity services. The amalgamation and merger of some hospitals may well be necessary in some areas where there is duplication of services and where it is necessary to concentrate resources into larger units. Many of these hospitals are blighted by being locked into PFI contracts to pay for new buildings. The annual payments for which often amount to 10% of their turnover. Controversially hospitals built under PFI could threaten services at neighbouring hospitals which could be made to close to spare the PFI hospitals which are too expensive to shut. Nigel Edwards the outgoing chief executive of the NHS Confederation said "If you are one of these hospitals and have a PFI you are really in trouble. You are locked into a 25 year availability payment. Even if you stop using the space you still paying for it". With hospital income set to fall the proportion of turnover taken by PFI will rise. Keith Palmer, a former Rothschild banker and NHS trust chairman said that "this is murderous position to be in because efficiency savings have to come out of smaller part of the budget".

The root of these problems lies in the concept that 'NHS hospitals are supposed to run themselves as modern businesses with income related to the number of patients treated'.

This business concept for healthcare is widely held throughout the political spectrum. Somehow we need to convince our political masters that healthcare is not a business but service.

Nobody would suggest that the armed forces should be run like a business. The country needs to be defended and the appropriate budget (albeit now reduced) is provided. So it should be for health care. A defined population needs a certain level of services such as

A&E, acute surgery, obstetrics, cardiology etc. The quantity quality, and location of such services can be planned and should be provided without having to resort to business models. How these specialist services should be provided eg in hospitals or community, can be decided locally (provided we take care not to dumb them down). Over and above these, the government should explain what we can and what we cannot afford as it does for the armed forces. By getting rid of the business model approach identified by the purchaser provider split, introduced by the Thatcher government and now espoused by politicians of all parties, huge savings could be made. The process of commissioning, with the purchaser provider split, was estimated by the House of Common Health Committee (March 2010) to cost 14% of the total budget of the NHS. We should look to Scotland where their health service is run by fourteen health boards and seems to work well with outcomes similar to those in England without using the business model of the internal market.

Together with the plan to make the NHS into a business rather than a service is the belief that competition will improve services and bring down costs. Part of this is patient choice. Of course if you ask people whether they would like choice they will naturally answer yes. However when it comes to an emergency most people hope that they could be taken to a hospital not too far away that was properly equipped and staffed appropriately to deal with them. For elective procedures most would like to take advice from their GP as he/she would be best placed to advise them. Sir Stephen Bubb CEO of the Association of Chief Executives of Voluntary Organisations and member of the Futures Forum, has written that the NHS must not be scared of competition "it pushes quality up, costs down and even saves lives- as long as patients are in charge" He also states that "it is a commonplace that giving more people more control over their own care ensure better health and saves lives". No evidence is shown to support this. People will be given personal budgets for their care, but how can we be sure that people will spend their budgets wisely and what happens when they run out? Underlying this plan is the mantra that everything in hospital (especially NHS) is expensive and bad and that all in the community is good and cheaper. He emphasises that care needs to be shifted away from hospitals because most patients have chronic disease which could and should be looked after in the community. We would probably all agree that many conditions can and should be dealt with mainly by primary care. However we must not achieve this by downgrading specialist services. These are needed to provide the specialist opinions and follow up of the more complex cases, to provide leadership and focus of knowledge in the particular field and to act as a hub with which to introduce and guide advances in treatment. Much so called community care is fairly second rate. So far as patient choice is concerned many patients prefer to be seen by a doctor specialising in their field rather than by nurse working from a protocol and who receives most of their up to date education from pharmaceutical representatives.

What people like Sir Stephen fail to recognise that if private companies are allowed to cherry pick the relatively cheap and profitable areas income to the hospital falls and then it becomes impossible to provide comprehensive care. The hope and desire for people to be admitted to a hospital which is fully staffed and equipped to deal with them in an emergency becomes impossible. The press has accused the profession, namely the BMA and Royal Colleges of opposing competition because of self- interest. In reality they oppose it to preserve the integrity of the services they provide in order to protect their patients from the folly of the bill. Doctors are naturally competitive people and many would not be averse to some form of competition. Why not compete to provide the best services and let the institution be rewarded for so doing ?

Integrated Care

The idea that different parts of the NHS should work together in a more formalised way seems to be only common sense. This concept is now gaining ground. Indeed Stephen Dorrell Health Secretary 1995-97 and chairman of the Commons Health Select Committee argued for this in the Times (May16th). He pointed out that acute hospitals, GP surgeries, community health services and social service departments have separate budgets, management structures and information systems. Previous efforts at improving efficiency have focussed on acute conditions involving diagnosis treatment and recovery. However most using the NHS have chronic conditions requiring long term care involving all these different parts of the care system. Here a more integrated approach is likely to yield better results and more effective care with implied efficiency savings.

Most clinicians would support these ideas and it may be one way of helping to achieve the £20 billion efficiency savings. The concept has been described in more detail by Ham et al 1. There can be integration between primary and secondary care and between health and social care. The example of Torbay is quoted. Here health and social care services and budgets for older people have been brought together. Integrated health and social care teams have been established in different localities and the work of each team is linked to several general practices. The teams employ health and social care coordinators who act as single point of contact and use the same assessment process to assess the needs of patients. The unified assessment process enables doctors, nurses, and other health professionals to share their knowledge of patients and facilitates the assessment process. In urban areas, especially London, where hospital providers are strong with several academic health science centres and primary care relatively less effective, hospitals could take the lead in setting up integrated care pathways. Imperial College NHS health care is pioneering integrated care in care of the elderly and the management of Type 2 diabetes. Common

information systems and multidisciplinary meeting involving both primary and secondary care doctors have been set up to discuss mutual patients. The hope is that the quality of care will improve and that hospital admission rated will be reduced thus saving costs. Some of the ideas behind this concept come from USA Veterans Health Administration This was transformed from a fragmented hospital based system into a series of regionally based integrated service networks. Twenty one networks provide comprehensive health care including chronic disease management. Hospital admission rate was reduced by 55% and quality of care compared well with other systems. It remains to be established whether this approach will be successful and whether Mr. Lansley would allow this system to go forward without trying to introduce competition between different integrated health care providers.

Finally we need to stop fiddling with the process and concentrate on the substance of health care delivery. Standards in both primary and secondary care need to improve. In hospitals, we need to seriously modify the European Working Time Directive and New Deal so that our junior doctors work sufficient hours to get the necessary experience and training and to provide the continuity of patient care which is so vital.

ROBERT ELKELES
Co Guest Editor

1. Ham C, Dixon J, Chantler C
Clinically integrated systems:
the future of NHS reform in England?
BMJ 2011 242 740-742

Is there a Funny Side of Adversity?

The Health and Social Welfare Bill trundles on relentlessly. This one-sided rugby scrum – *"crouch: touch : pause : engage"* – rather than engaging has disengaged and is heading for a pushover. Can you remember taking a trip into the countryside with a navigator who assures you that they know the way and will give you all the necessary instructions to get to your destination? Eventually you find yourself on a narrow farm track with nowhere to turn around. You respectfully reverse and after complicated redirections you only find yourself hours later heading down that self-same narrow farm track. You politely ask whether the map followed by your navigator might be the "Mapa Mundi?" Voltaire is quoted as saying, "O Lord, make our enemies ridiculous".

Today, we have no need to pray for God's help. The current administration has already made themselves ridiculous with their healthcare buffoonery, but there comes a point in time when being gentlemanly towards these ignoramuses has outrun its usefulness. All that is left is for us to deliver the rudiments of character assassination sufficient to cause them public embarrassment.

In that old music hall number, about a train journey to Birmingham which finishes up in Crewe, the lady in question readily admits that she has made the mistake,"O Mr Porter what a silly girl I am", whereas Andrew Lansley hasn't the grace to admit that he is barking up the wrong tree.

O Mr Lansley, whatever shall we do?
A wheel's come off your charabanc
And now you have no clue
How to get it sorted
Without a private deal.
So why not let them cut you up
and tell us how you feel?

O Mr Lansley, having had your paws
All over your disastrous bill
But hardly changed a clause.
You cannot win this battle
With Diego's "Hand of God"
O Mr Lansley you're a very silly s*d.

Jocularity however might only cause harmless amusement. Being a bit more personal could just tip the balance.

O Mr Lansley isn't it a shame
We've found the dirt that's tarnishing
Your sordid little game.
Time to go and clean up
And sort your laundry out
Or we'll take you to the cleaners and
wave the stuff about.

Of course there are other avenues to explore.

Slaves
Those Negro slaves working in the cotton fields and sugar plantations took their words and music from the Christian church and embellishing and fortifying them with their own passionate fervour, sought salvation not in this world but in a promised nirvana.

Or, was there a much more subtle message in their music making?

Having been sold by Arab slave traders, whose religious beliefs were at variance with Christianity, would they now enjoy the freedom and brotherly love of that new religion? Charity was not uppermost in the minds of those plantation slave owners and yet they would sing about brotherly love on Sundays! Just because you are a slave does not mean that you lack intelligence. How fitting therefore for your slaves to learn those words and sing them loud and clear and knock on those white diehard consciences until they could bear it no longer.

Unfortunately we cannot wait that long. Delay is likely to cause irreparable damage to the NHS. For those of us who are more pragmatic, hope and faith are mere staging posts in this world. Delivering the fruits of charity requires people with conviction and the preparedness to use their teeth to bite through the red tape that protects our politicians from the scrap heap.

Young Children
One thing that parents fear most of all is being embarrassed by their children in front of an audience.

A young child will readily learn by rote the words of a nursery rhyme. Most nursery rhymes are a mixture of make-believe and gobbledegook originally written by adults for adult consumption, so that understanding the meaning is never part of the memorising process.

The Camerons, Cleggs and Osbornes have between them eight children under the age of 10. If you add Lansley's second family that would add another two. Some will spend time with posh child minders others will be at primary school where exposure to the real world will begin and the opportunity to introduce perverse information.

Imagine if you will a birthday party for one of these delightful angels with the posh and some not so posh school friends accompanied by their doting mothers. After some boisterous running about exploring the territory, they sit down for the main event. Then full of cake and jelly one of these angels is persuaded to say her party piece.

The recitation of a well-known nursery rhyme is then followed by ten year old Luke spouting forth:

The currant buns at number ten
Are like Pinocchio.
For every time they say, "It's true",
Their noses seem to grow.

Followed by five year old Arthur:

Georgie porgie pudding and pie
Will kiss our NHS goodbye
Unless we gather up our skirts
And kick him where it really hurts.

Samantha and Frances exchange anxious looks. Miriam quickly comes to their rescue suggesting that Nancy, who has already been noted for her fine singing voice, might give them something genteel.

Sure enough, Nancy stands up and gives a rendering of the first verse of "They're Changing Guards at Buckingham Palace".

The mothers look relieved. Samantha beams with pride. The girls give appreciative applause. The boys look confused.

Nancy is encouraged to continue:

They are sharpening knives at
Westminster Palace.
The Downing Street boys look as sick as parrots.
The goose to lay their golden eggs
Is really a gander with bandy legs.
Says Alice!

The boys, hearing "bandy legs" sense something risqué. Nancy has in an instant become a kindergarten scarlet lady. General clamour for more.

Samantha blushes. Pride changes to embarrassment. God forbid. There might be worse lurking in Mother Hubbard's cupboard.

"Thank you Nancy. Anyone else for jelly?"

Retribution Has No Limits
In the middle ages the Pope and his cardinals were not slow in outlawing any challenge to their geocentric dogma about the universe. Punishment by excommunication or execution was the order of the day.

Taking our gloves off to match the politicians punch for punch is likely to be a messy affair, but without that our children will inherit what we have failed to defend.

Lansley and Co need to be brought face to face with their opponents and made to defend their dogma and rhetoric like real gentlemen.

When **logic** is founded on ***falsehoods***
And **wisdom** is tarnished with ***greed***
And **ethics** are clouds in your ***conscience***
Then why should your Health Bill succeed?

MARK AITKEN

A Story of True Love

A local East Yorkshire Vet was summoned by an old lady to come and see her poorly cat.

By the time he arrived the cat was dead.

Old Lady:-- "Will you arrange for her cremation and get me an urn for her ashes?

Vet:--- "Yes I'll do that. Didn't you have your husband cremated and ask for his ashes?

Old Lady:-- "You bet I did!"

Vet:--- "Out of interest, what did you do with them?

Old Lady:-- *(walking up to the mantelpiece and pointing to an hour glass timer)* "There they are—he never did an honest day's work in his life when he was alive---but I make the bu**er work now. Every time I walk past him I turn him over.

The NHS Reforms

When discussing the reform of the reforming health bill, the proverbial Irishman would have said that he did not want to start from here! But, one year on, here we are with some major changes to the Bill achieved partly through heavy lobbying by the RCP, including achieving hospital doctor representation on committees and Boards at local and national level, and a reversal of the proposed role of Monitor, which will no longer promote competition as an end in itself. At the same time, there has been major destabilisation of the SHAs and PCTs, and indeed of the whole NHS, which is creaking at the seams as it faces an increasing workload in the face of unprecedented and progressive savings targets over the next few years. And the process is still unfinished!

One critical premise of the 2009 Coalition reforms was to drive integration of primary and secondary care, as my College advocated in our guide "Teams without Walls" in 2008, and so by analogy we have termed today's situation "Commissioning without Walls"; but this has not yet caught on! Some of the changes could have been achieved, I believe, simply by introducing clinicians on to the PCT Boards. We agree with the Government that clinicians of all types, primary and secondary care doctors, public health specialists and nurses should be fully involved in commissioning. We argued strongly for at least one secondary care clinician on the now renamed local Clinical Commissioning Groups, and in their reply to the Listening Forum the Government has agreed. This is not tokenism, for I believe that this person, appointed by due process, could be the voice of balancing reason when the Groups seek to extract money out of hospital budgets by reducing referrals or tariffs. Conversely, we have argued, so far unsuccessfully, that a general practitioner should sit on hospital boards; indeed in some places this is being tried. It may sound provocative, but might it not be better if all primary and secondary care came under one employer? The current mix of employment in primary care does not encourage integration; indeed, many hospital trusts have taken on the provision of some community services shed by PCTs.

Perhaps even more important to a successful NHS is better integration of health and social care. We all know how difficult it is to discharge frail, elderly patients from hospital, and yet prolonging hospital care increases associated conditions, such as pressure ulcers and confusion. And yet I find in hospitals around the country evidence of considerable bed blocking, which is expensive in terms of staff costs, and delays the transfer of both acutely ill patients from admission units into wards, and elective patients into surgical beds. Health and Well Being boards may help, as they will be run by the local authority and incorporate social care and public health, but would it not be better if they were truly integrated, as they have tried with some success in Torbay?

The second plank of the reforms was competition and choice. Choice is a many faceted word, for most clinicians believe that they really do offer choice when they discuss treatment options with their patients. However, evidence, as always from the USA, shows that providing patients with details of options before seeing the specialist can lead to fewer procedures, better outcomes and more satisfaction, without prolonging consultations - so-called shared decision making. Do not jeer. I believe it does help, but it may not always be in the patient's best interests as viewed by the clinician. Our patient network at the RCP reports that they do not want choice of hospital, but instead a good hospital for everyone, even if it necessitates some travel; surveys purporting to show that patients want much choice, other than over logistics, are flawed and dishonest. Real choice also does not come cheap.

Competition is, of course, already with us, in that there is currently much private or voluntary provision within the NHS in renal dialysis and mental health, and in outsourced supporting services, such as pathology. But I fear full competition between hospitals and services. Professional competition between professionals and units can drive up standards, but any movement of services out has to be done carefully so as not to destabilise hospitals and remove the specialists away to another site so their expertise is not then available for other patients. I am suspicious, therefore, of "disruptive innovation", much lauded by those in the business sector. Indeed, many argue that competition between providers in the USA has led to over-investment in equipment and techniques to attract patients with insurance cover. Certainly, the use of independent sector treatment centres probably forced changes in NHS elective surgery, but at a large and inefficient cost and by paying extra fees to NHS employees. Similarly, hospitals built under the private finance initiative have turned out to be unnecessarily expensive white elephants that are adversely affecting the balance sheets of many hospital trusts. The regulator Monitor is surprisingly now charged not with urging competition, but instead with integration! On face value this is a U-turn, in which a carnivore becomes an herbivore, and I am suspicious that Monitor may not turn out to be as sceptical of non-integrated private providers as we would hope, although, to be fair, this is forcefully denied.

While in this vein, I personally support raising the cap on private medicine in NHS hospitals, back to what it was until the 1970's, for private clinics and beds can

bring in much needed income, drive up standards of services, keep clinicians on site (i.e. geographically full-time) and bring in particular clinical practice for education and training. However, it has to be carefully ring fenced within the hospital, for otherwise it has been reasonably criticised for potentially leading to queue jumping for diagnostic services or on surgical waiting lists.

The Government is still talking about personal health budgets. The College and its patient network currently oppose them. Personal care budgets can work, when patients with chronic conditions choose between, say, physiotherapy or an home help, but health budgets are scary, and there is evidence from pilots of much difficulty with the complex administration and the choices that are made. I do hope the DoH moves slowly and carefully; and there are several more pilots in progress. There is still little evidence that they improve health outcomes.

The management structure of the bright new NHS is uncertain and in flux. There will be a national commissioning board, overseen by the CEO of the NHS, one Sir David Nicholson Hon FRCP, and it will have advisory clinical boards beneath it. Although the SHAs are disintegrating, from their ashes will probably arise four sectors (going back to wartime words?), where commissioning of less common conditions, and reconfiguration decisions, may be made. Then, we are told, there will be clinical senates that may give advice to these sectors and to clusters of clinical commissioning groups, and finally clinical networks of clinicians coordinating specialised care. Where, one has to wonder, is the saving in bureaucracy that we were promised was one of the reasons for the reforms? George Orwell would have been amused! The other reason was that the NHS was failing, which is not true; such a judgement does little to encourage its staff, and anyway, international comparisons with the NHS are generally favourable, particularly on cost.

Attached to the reforms is the consultative white paper on education and training. This has rightly been fiercely attacked by all and sundry, mainly because it was obscurely written, probably in a hurry, and poorly thought out. It seemed to propose removing postgraduate deans from the SHAs, and giving control of training posts and their funding to the "providers" - presumably the employers. Fortunately the story is changing due to the advice of RCP and many others, and there will be a central body – Health Education England, morphed from the current Medical Education England, that will hold the budget for health professionals in training, and will pass this money through the deans. We favour placing the newly preserved deans in medical schools to increase linkage between undergraduate and postgraduate education. Otherwise the proposals have thankfully been put on hold, but I remain suspicious!

Behind all this is the Nicholson Challenge of saving £20bn over five years while at the same time coping with the increasingly elderly and sick patients, and offering always more expensive but better treatments, which lead to longer survival and then more treatment later! I cannot see that these savings are possible without visible damage, and there are already signs that the service is creaking, underlined by my visits around the regions. I believe the Government must soon put more money into the NHS, and that the public want them to do so. We shall see, but meanwhile hospital doctors struggle to maintain the secondary care service, together with our hard pressed nursing colleagues.

I remain unconvinced by the data that improvements in care in the community will suddenly reduce the need for admissions to hospital for acute and elective care. One day perhaps, but better care in the community, by improving diagnosis, can also increase referrals to hospital. Meanwhile the problems of public health crowd upon us. Smoking is still prevalent, alcohol is a greatly increasing problem, and obesity is causing the tidal wave of diabetes - 15-20% of in-patients suffer from diabetes. That is why public health is key, and we cautiously welcome, as does our Faculty of Public Health, the proposal for an agency, Public Health England, separate from the DoH, and a network of public health professionals placed in local authorities, and answerable directly to their chief executives. David Cameron agrees with us that improving Public Health is the final solution.

Finally, can real savings be made? Reconfiguration (ie: mergers, take-overs, closures) may help, but are often drowned in local political quagmires. At least they concentrate clinical services, but do they really save money? The rapacious PFI agreements are being renegotiated. Savings could be made on drug budgets if the Government forced PCTs to follow NICE guidelines on drugs and stick to generics, but it will not. Procurement could be centralised and made more economic. Land could be sold off. The gross variations in lengths of stay and procedures could be made more uniform, perhaps by accreditation of local speciality services – but £5bn a year in the face of an increasing acute clinical load –any independent financial adviser would raise his eyebrows. As I have said, will there really be savings from bureaucratic changes?

The last 12 months have been a political football game. The next year will be much of the same as the Peers get their teeth into the Bill in the autumn, the signs of distress in the NHS increase, and the chess pieces of the new bureaucracy are moved around some more.

Sooner or later I shall be a patient, and I fear for the Service in which I still so passionately believe.

SIR RICHARD THOMPSON PRCP

....and Just a Couple of Nursery Rhymes to add to Mark Aitkens Reflections on the Bill.....

(With apologies to the Executive Committee who have already had to put up with these and others' on e-mail!)

Sing a Song of Sixpence

Sing a song of health care
A pocket full of hope.
All those earnest Lib-Dems,
What a blooming joke.
When the vote was open
They all forgot to shout
And now our dear old NHS
Is going up the spout.

Osborne's in his counting house
Counting out the dough,
Which Lansley has to generate
Or else he has to go.
Clegg is in the garden
Burying the Bill
And muttering quietly to himself
"Have I a future still?"

Pussy's in the Well

Ding dong bell, health plans don't half smell.

What's the latest cause?
Cameron's perfumed "pause".

Who'll sort them out?
Sadly, there's much doubt

Lib-Dems under Clegg
just simper, pose and beg.

This Bill with all it's faults
should finish in the vaults.

With all that private bread the NHS is dead.

G.M

Some Reflections on The NHS by a Retired Paediatrician

Streams of hypocrisy continue to issue from Cameron and his party. Vows of faith in, and loyalty to the NHS alternate with reiterated intentions to draw in volunteers and commercial companies to take over as many public functions as possible. Little distinction is made between voluntary and commercial; it is possible that more volunteers would be useful, and they should not at least prove harmful, providing enough could be found and depending on what they are asked to do.

But the commercial companies are a different ball game altogether, as we all know.

Friends of mine ask why they should be worried about this-what is wrong with private firms taking on a limited amount of work on behalf of the NHS? Well, I reply, just take a look at some of the contracted –out services already in place.

Cleaning and hygiene have been sub-standard in many hospitals, and there is no direct control over their staff who have often been asked to accept wage cuts and who no longer feel any pride in their job, or any sense of belonging to a much larger benign entity as before.

Even if some GP surgeries for instance, are functioning adequately at present, there is no guarantee that gradually the pressure of the profit-motive will not see unwelcome changes impinging on patients. Many of these smooth young Conservatives seem blind to these pressures and continue to try to pull the wool over the eyes of an unsuspecting public.

Those who remember the conditions prevailing before the founding of the NHS must feel increasingly uneasy about the creeping privatisation we are seeing, especially the less well-off.

Why are the media so laid back? It's rare to hear any praise for the NHS ethos or services. Neither do we hear much about the benefits of working in the public sector.

Unions are very concerned about job cuts and conditions, and rightly so. But the general public still hasn't grasped the full implications of the Health and Social Care Bill.

The bad tales one hears about faults in the service are often concerned with cases of poor communication between GPs and the hospital sector.

A friend of mine who had a partial colectomy was given no follow –up appointment, and when he began to complain of pain and malaise he had great difficulty in getting to see the surgeons concerned. By the time his large surgical abscess was drained, he had lost much weight and six months later is still thin and lacking energy. I don't know if any of his problems arose from pressures within the system to limit re-referrals, but it is disturbing that his GPs were so slow to realise that this was a genuine and serious condition. Such cases will always occur, but they will be more frequent with increased pressure to limit admissions.

Costs are continuing to rise. There must be much unease in Government and administration about the demographic "time-bomb". An ageing population requires increased expenditure. This is of concern certainly among health services in rich and moderately rich countries if not globally. A combined approach may throw up solutions not apparent now.

At the other end of the age range, intensive neonatal care costs continue to rise. There may be cause for reconsideration of the treatment of extremely immature babies. In this group, even with excellent care (which is the rule rather than the exception) there are going to be survivors with more or less serious disabilities.

Having already incurred costs from intensive care as neonates, they continue to need therapy and special education and a great deal of parental care.
I emphasise that I am discussing only the extremely premature, below 24 weeks gestation, or those with recognisable severe brain damage at a later gestational age.

As a retired paediatrician I am well aware of the very difficult choices facing neonatologists with these infants. Even more ingenious technical progress has been made but still the handicap rate stays much the same. There is a danger of treating barely viable infants because you can, not because you ought. Although parents' wishes are very important, and they need to be as fully informed as possible, there is often very limited time to fully discuss the options and make decisions.

There are no easy answers to such problems, but we must be mindful of the costs, both financial and humanitarian.

ANDREW PORTER
Paediatrician

Political Activity

There has been a great deal going on and those members for whom we have email addresses will already be aware of some of the detail of the activities including those of KONP, the NHS Support Federation (both closely linked to and indeed founded by NHSCA) and other organizations like 38 degrees.

The NHSCA website, whose management has recently been taken on with great energy and enthusiasm by Mark Aitken, contains a wealth of information.

One of the key events has been the vote at BMA Council to mount a public campaign for the withdrawal of the Bill, a result binding on the BMA leadership, although it has to be said that at the time of going to press there is little evidence that this is being pursued with the necessary urgency.

That we have got thus far is largely due to the untiring efforts of NHSCA members on Council; Jacky Davis, Clive Peedell and Anna Athow, supported by other like minded Council colleagues. A persistent and eloquent tail appears to have wagged a rather reluctant dog.

Other news stories, most recently the riots in our major cities and the ensuing political arguments, have tended to crowd the NHS out of the media spotlight but great efforts are being made to ensure publicity as the Bill returns to the Commons for the Report Stage in early September before – if it is not thrown out – it goes to the Lords where it could well spend most of the rest of this year.

Meetings with politicians have been increasingly difficult to achieve but persistent efforts by Harry Keen have finally come to fruition with a date to meet Shadow Health Secretary John Healey. Harry, Wendy Savage and I will be seeing him on 13th September.

The official opposition is now firmly opposed to the Bill so we will have much to agree on there but we will want to use the opportunity to make the case that even if this Bill were to fall, the NHS will remain vulnerable to further such attempts until we in England come to our senses and abolish the Purchaser-Provider split and all that stems from it, as the rest of the UK has already done.

As you will have seen from the June Newsletter and the letter you will have now received inviting you to the AGM, most of that event will be devoted to how we can best work to achieve these two objectives.

The news arrived too late for that letter but in addition to those contributors listed, we can now report that Mark Drakeford, Member of the Assembly for Wales and Chair of its Health and Social Care committee, has agreed to participate. He should be very well placed to give us the facts on how NHS Wales abandoned market based theories in favour of a system based on cooperation.

As individuals there is much we can do like letters to national and local press, approaches to MPs and increasingly importantly, to members of the House of Lords.

Also important are the everyday conversations we have, not just with medical colleagues but with members of the public we come across in all sorts of ways.

Some of our members have asked for background information to help in these encounters.

There is so much material about that it can be difficult to select but something that could be very useful was spotted by Clive Peedell and has been circulated by email and also put on the website.
For those who haven't seen it there are two links:-

The first **http://conservativehome.blogs.com/files/the-nhs-bill.pdf** is the document sent out by the Coalition government to Conservative and Lib Dem MPs, setting out the Bill's intentions and listing what it refers to as the Myths about the Bill and the arguments to use in refuting them.

The second **https://sites.google.com/site/nhsfuture/Home** takes you to a website which provides the counter arguments, showing that far from being myths these are well founded criticisms.

Another source of information can be found in the quarterly journal Renewal at **http://renewal.org.uk/articles/the-plot-against-the-nhs/**

This gives a précis of the book "The Plot against the NHS" by Colin Leys and Stewart Player which some members will have read and a postscript on the Bill and its halting progress.
We look forward to being able to report in the December Newsletter how the Bill was defeated by the combined efforts of many organizations and individuals.

PETER FISHER

A Personal View of the NHS

I have been asked to provide a short personal assessment of the NHS – Past and Present.

I am, I suppose, fairly qualified to give an opinion based on my 43 years in General Practice in the North East of England. My overall assessment of my time in General Practice is one of generally incredible satisfaction with the concept of 24 hour care and an opportunity to get to know and relate closely with old and young in the community – not only professionally but also socially.

Until perhaps the last 10 years the original concept introduced in 1948 of total medical care –'free at the point of need' has been a very comfortable way of practising without any real restrictions on the type of medical, surgical and social need; we have never, till recently, had to inform patients that a particular course of treatment may not be available freely on the NHS. However the changing face of health care demands has meant that the concept of 'rationing' has come into the equation – such as the Herceptin /breast cancer issues which invoked accusations of a 'post code lottery' of treatments.

As I look back over the years it has become obvious that the increasing demands on the NHS budget from the many 'new' treatments (such as stem cell therapies) and the huge increase in the care of aging and degenerative diseases (hip and knee replacements, targeted surgical procedures such as arterial stenting etc.) has introduced an ever increasing demand on resources. Unless we believe in magical, cheap discoveries in medical science soon the pressure to provide this service in an aging population will only increase rapidly.

So how do we cope with this practical and financial assault? Well it is clear to me that the current funding of the NHS will in no way cope. We - as commissioners - are being asked to provide all embracing services – as well as saving millions of pounds! It just cannot be done.

I have thought long and hard about the solutions and obviously there is no painless way. I feel we, the Medical Profession and the Government(s) of the day must at some stage grasp the nettle and introduce some form of incentivised Personal Insurance arrangements which would finance the 'non urgent or essential' treatments. Several

countries such as France and Canada already have contributory costs which are the responsibility of the patient. I value the concept of the 'original' NHS so much that I would like to see it preserved in a modified form that would care for the vast majority of patient needs from birth to death but EXCLUDE certain prescribed non life- saving procedures and medications such as joint replacement, certain vascular and ultra expensive therapies. – possibly even infertility treatment etc. These would need to be covered by this additional insurance policy – overseen by Government and possibly with private providers whereby a percentage of income on a sliding scale and perhaps with some tax incentive would be apportioned for these 'extra' services in later life. (I suppose not unlike Extended Warranties with electrical goods!!).

Perforce this may need to be optional rather than mandatory and would need to be introduced very gradually with the implications of non involvement being highlighted (with the endorsement and advice of medical professionals).

I realise no Government or health professional wants to tamper fundamentally with the original concepts of the NHS for Political reasons but the efforts in the past 20 years to move to commissioning have in general been rushed and neither thought - through nor piloted properly – hence current despair over the stop/start nature of the current Bill. However if we are going to change to a more fundamental NHS I feel it should be driven – not just by government- but also by Health Professionals. We HAVE to take a lead in reforms with Government over a period of time – to get it right and inform the public of the long term issues. Ideally one would not want a 2 tier system of care but I can see no other way of providing a good, caring medical service to all – but not necessarily a service that covers ALL non critical procedures. I still feel the GP is the person who can and should act as gatekeeper and councillor to the patient. This would become a more comprehensive role if medical and social contact between Primary and Secondary Care was to improve- as surely it must do.

Also in general I do not personally believe that the majority of Patients care about 'Choice'. I feel they want good quality assessment and investigation with either a diagnosis or programme of further investigation. They prefer to be directed by their GP along this path (not by impersonal ' Choose and Book' but by their GP's assessment of who is the right person for their secondary care).

My views may not resonate with other health professionals (or managers) – but if nothing else I am pleased to air them!

CAMERON DAVIDSON

Reality Check, Please.

Our NHS –what does the future hold? One thing is clear, the current uncertainty cannot be allowed to perpetuate disaffection and hopelessness. Media comment has been labelled 'the clinicians', 'the management', 'the government', 'the unions', 'the patients' as if these were separate and unconnected. They aren't. They are all part of the same system.

Thinking by type is inevitable in an organisation grown as huge as the health service – it's too big to comprehend as a unified whole - but that thinking will set group against group and further fragment a service already losing its credibility as a recognisable entity. The NHS bureaucracy talks to itself in code, and drowns in its own mythology. Too much is too coy. The money won't stretch any more but we are pretending the changes are to 'drive up quality', 'promote patient-centredness' and 'generate efficiencies'. Honesty and sense requires we tell it like it is, that much that has been done for us we shall have to do for ourselves and much that the service will still be able do for us will be only the essential not the preferred. There is far less money and many more patients and the only way to square the circle is to delete work at the bottom of the priorities' ladder. Patients will not like this but they will have to learn. They need to be involved in honest sharing, not pandered to. That clinical possibilities are running ahead of the ability to fund them has supported the illusion that if only we had 'the right health service' it could address all ills. It can't.

For too long, a culture of dependency has allowed citizens to abdicate responsibility for their own well being. An orgy of irresponsibility has spawned unnecessary epidemics of obesity, diabetes, liver disease, and heart disease. Local authorities allow cheap takeaways to populate the high street and open opposite the school gates. Lack of exercise and commercial sexualisation jeopardise the young. Social mobility or familial indifference abandons the elderly. Individualism has become selfishness. The state's safety net has been overwhelmed.

The wake-up call will not come in words but in deeds. Patients made to wait much longer for operations, or refused treatments on the grounds of minimal clinical benefit, or the rationing of medication, will bring the reality check. Unfortunately, some of those who will experience this reality will not be those who have most bankrupted the system.

So in this new harsher reality, who chooses? Certainly not those who clog A and E every Friday and Saturday night with their self inflicted drunkenness. Not the single mothers for whom a pram to push at sixteen is a passport to benefits. Not the can't cook/won't cook generation. But not just the bureaucrats either.

To date, any working with the patients and public has been pretty deplorable. For example, GPs are currently being offered £1.10p for every patient on their list if the practice starts a Patient Reference Group . If this were a clinical trial there would have to be informed consent. A clinician cannot even take blood pressure without consent, for fear of being charged with bondage, yet now we have central policy and toolkits to get GPs to use their patients, invisibly incentivised by money! Should the GP say, ' Fill this in for me, you're worth £1.10p a head'? Is that what the patient is worth, half the price of a hamster? Worth should reflect cost.

I worked for a long time with a senior group of clinicians, the group chaired by one Prof and attended by another. Spats and sparring was common between these two but we understood it as their safety valve, their way of coping with a working lifetime spent giving-out to desperately sick people, some of whom were on a one-way street, all of whom they cared deeply about. They dealt with their reality by involving themselves with their patients without patronage, deceit or self interest. They were real as human beings, as their patients were to them.

We should learn from this. Truth, however grim, is easier to manage than fear and fear we currently have in abundance about the future of our health service. Tell the public the reality. Put an indicative price tag to procedures and prescriptions, investigations and operations. Share the basic arithmetic, make plain the sums involved. It will never be possible to show all the nuances of pricing and on-costs, but shatter the illusion that health care is free. It isn't. The available envelope of monies, just or unjust, rationally allocated or not, historical or current, factored or unfactored, adjusted for market forces factors or whatever – it does not matter. It is a headline sum that when spent brings the service to a halt.

The services can then be directed, prioritised, to those whose need is greatest and for whom the outcomes are best. Trying to do something, just because medical science can, is profligate. Doing it because it genuinely adds to the quality of life years is sense. The health service was created to attack sickness and address genuine accidents and emergencies, not undertake IVF, cosmetic enhancements, overeating, substance abuse and the like. The NHS has lost its way, fed unrealistic expectations, squandered its talents. A hard line is needed. The public will not like it, but will know where it stands. It will have to confront the reality. It can then be invited to share the decisions and must live with them. If it abdicates from this decision making, it has only itself to blame.

RUTH MARSDEN
Vice Chair,
National Association of LINks members

Oxymoronic Medicine

The NHS has changed. When I began in it as a medical student over 40 years ago it was designed to help patients, and the medical staff planned the services, while the administrators tried to help them. This is now turned on its head. Managers make the decisions, and the clinical staff try to go along with them (or not, as the case may be). Instead of a service centred on patients it is a service obsessed with budgets and I have seen many clinicians blindly following ludicrous policies because they have been ordered to.

An oxymoron is a figure of speech in which two contradictory terms combine to produce an incongruous effect. Medicine is now full of them. They bedevil strategy, planning and execution. Some are incomprehensibly stupid. At least I think so – but increasingly some of the madness of the NHS that I have pointed out in various fora (not least the correspondence columns of "The Times") appear to have struck a chord.

Here then are some of them.

1. **PFI has enabled the renewal of many hospitals**

   The system of Private Finance Initiative or PFI for short is a reflection of the entire banking crisis of the first decade of the 21st century, which was driven by unaffordable borrowing. If you cannot afford a mortgage you do not buy a house. If you own a house you do not expect to have to sell it to pay someone else's mortgage.

PFI buys hospitals on long mortgages at high interest rates that are fixed for the term of the PFI – commonly 25-35 years. My own rehabilitation unit, capital cost £1.2m, had an annual PFI recharge of £650k. Assuming an interest rate of 6% - fairly standard for PFIs – that left an unexplained annual charge of £590k. Despite numerous requests all I was ever told was that this was "right", until my persistence was rewarded with the news that it no longer was an issue and had been "lost". I wish I had half a million a year to lose!

When four hospitals in SE London were planned to merge, an internal finance analysis stated that the PFI payments on two of them were so large that it would be impossible to cover the costs from income. S London Healthcare Trust, comprising three of the four, is now the second most financially challenged in the country. Hardly surprising then that a slash and burn policy of "rationalisation" (in part rather dubiously disguised as clinical improvement) dismembered the non-PFI hospital which according to the figures was the only part of the organisation that broke even.

In financially challenged times it is ludicrous to persist with unsustainable borrowing. There are two oxymorons here; one is that it is denied that PFI is contributing to NHS deficits. A recent analysis is quoted as suggesting that the current NHS annual deficit is around £20bn. Curiously this is almost exactly the cost of PFI. The other is that all the borrowing has been kept off the government's balancesheet(whichhelpssustainthefirstargument).

2. **The NHS cannot run as a business if both purchaser and provider must make a profit out of the inadequate money supply**

I am not an economist, but as a relatively sane and savvy investor I cannot understand how one can have a sale and purchase system where both the buyer (currently the PCTs, which may change) and the provider (largely hospitals) can make a profit. If, in addition, the total money comes from a single outside source (the government) then if any part turns a profit the government has put too much money into the system, and if it turns a loss then it has put in too little. Much has been made of the fact that many "challenged" organisations are in urban areas and are to a great extent concentrated round London. However it has been forgotten that some years ago a deliberate redistribution of government money robbed the South to pay the North. So we can safely assume that the Trusts and PCTs turning a profit are overfunded. That's not to say that some problems may arise from poor management, but in my experience they are only nibbles around the fringes. Not least with the PFI bogey…

It is also an oxymoron to talk of "investment" in the NHS. Investment implies someone makes a return from it. The government never has, and never can. So why dress it up as investment when it is just spending? Unless of course you are one of those providing PFI money with that guaranteed 6% return

3. **The NHS cannot run as a business if a failing part of it is continually propped up**

If we pursue the business model then we look at stock market quoted companies that cannot turn a profit. They go bust. But it is only in the last six months or so that there has been any talk of letting "failing" parts of the NHS fold up and close. Yet, as in (1) above, because of the unavoidable debts incurred from PFI which are immutable over long periods – six times the length of a government – these unaffordable units are kept open while the non-PFI units that are not debt-ridden are the ones at most risk.

4. **The NHS is bust, and we must save money without cutting services, but nevertheless must waste money on the absurd**

I remain appalled by the astonishing waste of time and energy on the peripheral. For example, I was supposed to go through a series of annual updates on fire precautions and moving and handling, prove my competence in infection control, check my stance on equality and diversity and various other things that either took me away from clinical work to attend dimwitted lectures or forced me to do lengthy, illiterate net-based teaching modules. Likewise large sums are spent on hiring speakers for all sorts of "educational" events which then are cancelled because no-one signs up to go. Or expensive conferences are held for exchanges of views, which often try and sell ideas from elsewhere in the world.

Some 20 years ago a US doctor suggested to me that many of our system changes derived from US practice were being introduced just as they were being abandoned in the US. I recently saw a doctor currently practising in the USA who was thinking of relocating to England and was interested in my job when I retired from the NHS. I outlined my understanding of the way the NHS was going and the increasing restrictions on my clinical practice to his increasing disbelief. He then told me that he had been through similar system changes in the US some 10 years previously, and all they had done was increase dissatisfaction among staff and lower morale.

Plus ça change.

5. Care in the community is better

"Care closer to home" has been a mantra for successive governments (and some senior doctors). They have forgotten that there are many virtues in concentrating resources. Big hospitals offer unparalleled opportunities for doctors, students and academics to share experience and improve practice. Multidisciplinary working becomes fragmented or impossible in many community settings. Neither is there much good evidence to suggest that good community-based care is any cheaper than hospital-based care; indeed if one looks at supermarket strategies you find that corner shops such as Tesco Express trade at a premium to the superstores.

The only reason community care is cheaper is that there is less of it. A further internal oxymoron is, of course, that the closure of "uneconomic" units leads to fewer, more widely spaced hospitals, so care is actually further from home.

We need to understand that if better is not cheaper, then we must assess affordability. I cannot afford to drive a Bentley (also it won't fit in my parking space in Rye) so I don't.

6. Community hospitals are the way forward

In the light of the above it may seem strange to have this on the list. But it springs direct from the oxymoronic mouth of no less an NHS dignitary than Sir David Nicholson. At the launch meeting for the NHS Constitution in 2007 he praised in fulsome terms the development of a new community hospital on his home patch (Chipping Something). It was all I could do not to stand up and ask why, if this was such a great idea, so many cottage hospitals had closed in the last 25 years because they were uneconomic (back to the Tesco analogy).

Of course, if outside funding, such as direct charity funding from the local community, can prop the things up then that is fine, but we are in danger of returning to the pre-NHS system of voluntary hospitals, many of which were only saved from closure in 1948 because the NHS took them on. A fragile system is not a good system.

And I would challenge Nicholson, who has firmly said this year that failing organisations must close, to guarantee that his Chipping Somewhere hospital will be shut down if it fails to break even.

7. More money than ever before is spent on the NHS

More than one government has, sulkily and with a puzzled and aggrieved air, pointed out that it is spending more on the NHS than ever before so (1) why is everyone complaining and (2) why isn't productivity going up.

Well. The first oxymoron is that much of what goes in goes straight out again. PFI payments cost £20bn annually, as mentioned above. Employers' National Insurance and pension contributions have both increased significantly (and the government(s) fail to credit the recouping of employees' raised contributions). The second is the European Working Time Directive. Doctors work a third less hours than they would otherwise. The consultant and GP contracts meant they were paid more. To square that up against productivity would require them to work in a superhuman way to maintain their workload / salary balance.

Is this *really* so hard to grasp?

8. Outpatient follow-ups are inefficient

This is a small issue, but it underlines the lack of financial understanding in many parts of the NHS.[1]

A national directive required follow-up numbers to be reduced, on the grounds that many follow-ups were unnecessary and therefore wasted money. The policy was applied in blanket fashion, including chronic disease specialties such as rheumatology and neurology. This would have had the effect of abandoning patients with diseases requiring specialist regular assessment and on specialist drugs requiring careful specialist supervision. Many discharged patients would have to be re-referred as new ones – and thus a "cheap" follow-up appointment would be replaced by a more expensive new appointment. Or else they would get lost to the system, with potentially awful clinical consequences. For chronic disease you need specialist follow-up; for research you need long-term patient cohorts. So not only is it oxymoronic to imagine you will save money, but you will potentially damage research.

9. And lastly.....

Let us assume that all of my arguments about the madness of trying to run a purchaser-provider model where everyone makes a profit are wrong. Let us assume that providers will happily do the work sent to them by GPs, and the purchasers will happily pay.

Only they won't. More than once in the last five years my hospital submitted its bills for the work done and the PCT refused to pay. It then said it

would not allow any increase in activity year on year, quite disregarding the notion that operations get done when they are needed, not because wild-eyed orthopaedic surgeons are trying to boost their hospital income (indeed, oxymoronically, quite the opposite, for instead of sitting twiddling their NHS thumbs or putting up with inadequate theatre supplies they could slope off to the local private hospital, where they get paid more and may even end up doing the same work because the PCT has suddenly realised it has a waiting list issue and starts buying work from alternative sources. Of course it doesn't always pay for that either).

On the other hand PCTs have been very happy to enter into ill-researched block contracts with private organisations and then pay for work that was never done because the contract size was greater than the demand. An oxymoron if ever there was.

Is there an answer? If you are over 60 I suggest you retire at once (I am much happier, and have lost a stone in weight!). If not I suggest you understand the oxymorons and take a last lesson from an old hand like me – namely that you can reorganise all you like but that none of it will, from my long experience, make any difference. Keep calm and carry on!

DR ANDREW BAMJI FRCP
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Dr Bamji retired from the NHS in May 2011 and now works one day a week in the private sector. He was President of the British Society for Rheumatology from 2006-2008. He has had 60 letters published in "The Times", mainly on medical topics.

[1] Bamji A. We should scrap targets for outpatient follow-up ratios. BMJ 2011; 342: c7450

The AGM and Conference 2011

Saturday 1st October at Bedern Hall, York

Details of this event, with application form, were sent to all members in mid August.

If any have gone astray, got lost, been overlooked etc, duplicates can be obtained from NHSCA – contact details at foot of this page.

New Members