NHSCA

EDITORIAL September 2012

How the NHS was lost

We really ought to have a black border around the latest edition of the Newsletter, to mark the death of the UK National Health Service. After a 2 year fight, the infamous Health and Social Care Bill finally became law earlier this year. The legislation was bulldozed through parliament with the assistance of the Liberal Democrats, a scandalous betrayal which will not be forgotten or forgiven. In its final stages it was encumbered with over a thousand amendments and is now even more Byzantine and dangerous than when it first saw the light of day. It was opposed by every major organization representing health care workers and degenerated from a bill sold as empowering doctors and patients to one battling the vested interests of the professionals. Its passage was a low point for democracy in this country. It became a matter of political pride and personal prestige, an arm wrestling match in which the coalition leadership had invested too much to back down.

It's worth recalling why it matters so much. This legislation is a bottle of snake oil, it doesn't do anything it promises on the label. Cuts costs? No, costs will rise, with the ever increasing financial burden of marketised care not to mention £3 billion+ for the 'reforms' themselves. Cuts bureaucracy? No, it replaces 3 layers with 7 and the CEO of the NHS Confederation has recently warned of a 'tsunami of bureaucracy'. Gives power to patients? No, patients will have less choice than ever thanks to management referral centres, reduced treatments, and the limited choice already present in some parts of the country where the private sector has taken over.

It certainly doesn't give power to doctors and front line staff. GPs will be answering to CSUs run by private companies and in London GPs have already been forced to pay for commissioning 'support' from the private sector. Management consultants like McKinsey have made millions so far and are anticipating many more millions to come. At the same time GPs are taking the blame for massive cuts in budget and we are already seeing headlines blaming doctors for service cuts and for denying care to patients.

Finally it cannot fail to adversely affect teaching and training, core functions of the NHS. No wonder the government defied the law and refused to release the risk register.

So the H&SC Act represents a massive redisorganisation of the service, so huge that according to the Big Beast himself, Sir David Nicholson (CEO of the NHS) it could be seen from outer space. How was it possible that such unwanted, undemocratic and destructive legislation could get through against the opposition of the profession? Part of the answer must be that there was a dreadful failure of medical leadership and much of the blame lies at the door of our representative bodies.

Many GPs were unfortunately but understandably attracted by the idea of commissioning while failing to notice that it came accompanied by less attractive elements including the drive to outsource any and all NHS services to the private sector. The BMA, with GPs in the driving seat, pronounce the bill to be a 'curate's egg', good in parts and announced that they would have the tasty bits and manage the rest, thus fatally missing the point of the tale of the curate's egg. Once part of the egg is rotten the whole thing is inedible and this is as true for the HSCB. It is woven of whole cloth, without the possibility of taking up the attractive parts (if indeed there ever were any) while rejecting the rest.

The BMA failed to consult its members over the HSCB, relied too heavily on political lobbying for 'significant amendments' which never materialised and resisted coming out in opposition to the bill until forced to by repeated emergency motions at Council. By then it was too late, and on the day the bill became law Andrew Lansley was still claiming that he had the support of the profession.

The Royal Colleges, with a couple of honourable exceptions, were the dog that didn't bark in the night. Not a sound was heard from most of them on a matter which would massively affect their members. They kept their heads down, discussing instead (in the case of my own college) important matters such as the move to a new building rather than legislation which would affect every aspect of their remit i.e. teaching, training and standards.

Finally in desperation at their silence several campaigners, led by David Wrigley, a GP from Cumbria, set up a website to encourage college members to formally request emergency meetings of their college so that they could call for opposition. The resistance of college officials to this move was a sight to behold, and many interesting conversations took place with people to whom it had clearly never occurred that the members might notice what was going on (or not going on) at college HQ, and what's more might have the temerity to question it. I'll forever treasure the memory of a phone call to someone at the RCS to say that we had enough members signed up to call for an emergency meeting. 'But I've never heard of you' was the bad tempered response. Well you have now and what's more we have the requisite number of names to request a meeting. The great and the good who represent us did not appreciate being called to account.

Once called to account almost all the colleges found themselves faced with overwhelming demands for opposition to the bill from their members. Even then there were delaying tactics but the message had gone out to the media that doctors were united in their opposition to the legislation. Unfortunately by then it was too late to stop the bill.

A shining exception to this behaviour was the RCGP, which regularly consulted its members and whose president, Clare Gerada spoke repeatedly about her concerns. Given the supine position of the rest this was a heroic thing to do, and attracted a lot of press coverage. Many firmly believe that if the whole medical establishment had had the courage to work together and speak out against the bill it could never have survived the joint onslaught of the profession. As it was the complicit enablers, through silence or, even worse, co-operation, betrayed the NHS, the profession and our patients. Shame on them, history will not remember them kindly.

So are the prophets of doom right, and is the NHS in England facing extinction? Well, the news coming in is not good and already we are seeing the vultures circling the NHS. Significant contracts have already gone to transnational corporations like Virgin and Serco, the biggest company you have never heard of. Virgin picked up community services in Surrey, where presumably patient choice now consists of Virgin or Virgin, and also 'integrated children's services' in Devon. As far as I know they have no experience of providing the latter but that doesn't seem to matter in the brave new world of outsourcing public services. The core business of these transnational companies is in winning government contracts regardless of what they are for. They have the experience, the legal expertise, and the deep pockets to allow loss leaders if necessary and it is simply unrealistic to think that small charities and social enterprises can take on these huge companies and win.

Once they have the contract they then put together the package, and the word is out that community paediatricians are being urgently sought, presumably to fulfil Virgin's new contract in Devon. It has been said that G4S, awarded the security contract for the Olympics, expected to take on operatives and deploy them 3 days later. This is no way to run any public service let alone the NHS and the G4S Olympic fiasco certainly seems to have alerted at least some in government to the dangers of outsourcing public services (1). Vital public services like the NHS can't just simply be allowed to disappear, and if private providers

fail or walk away when profits don't materialise then the government has to step in. The result is that profits are privatised while risk is socialised, a convenient scenario for the private sector but a recipe for disaster for the tax payer, the NHS and those who rely on it.

Elsewhere GPs are waking up to the real world of loss of autonomy to the Commissioning Board and to commissioning support services, which are likely to end up in the hands of – you've guessed – the private sector. At what stage will GPs decide that they can no longer ride the tiger of the HSC Act and that it would be better to show their disapproval with events by walking away from commissioning? There are still those who argue that they must remain involved otherwise 'others will do it' but that is the primrose path to hell. We underestimate our strength as a profession, but strength requires acting in unison which requires strong leadership. We are still waiting for it.

Meanwhile the 'Nicholson challenge' of 'saving' £20 billion makes a nonsense of promises that there would be no cuts to NHS services, and thousands of front line jobs have been lost already. And as longer and longer lists of treatments are excluded from the NHS menu as part of these McKinsey-driven "efficiency savings" fewer people will be offered an acceptable choice; instead many will have to choose between pain and discomfort or paying privately. Personal health budgets (PHBs) are another ideological move, designed to facilitate the path to top ups and co-payments while allowing top slicing by 20% to cope with the financial constraints. Martin McKee's article in the BMJ (2) described how the Dutch are moving away from PHBs while we are rushing to embrace them – yet another example of policy based evidence making?

There are too many other depressing stories related to the cuts and the 'reforms' to describe them all but you might like to consider that criminals can now run the NHS (3), that NHS patients will be able to 'self fund' (4), the role of the media during the listening pause (5), predictions about the privatisation of hospitals (6), how patients lost their sight at a private centre (7), and the scandal of over treatment in the USA (8) to chose but a few. And if you want more where those came from please follow Clive (@clivepeedell), myself (@DrJackyDavis) and KONP (@keepnhspublic) on Twitter. People who don't tweet often think that it is just about what Wayne Rooney did last night but if you ignore the celebrity trivia it is a wonderful campaigning tool. Depending on who you follow you can get all the news, articles and low down on health and medical politics and never need know what Madonna had for breakfast. Try it, you'll be pleasantly surprised, but - health warning – it is dangerously addictive.

On an up note the Olympics provided some great bread and circuses entertainment and Danny Boyle became an instant NHS hero when he featured the NHS during the opening ceremony. Needless to say Tory MPs immediately saw a conspiracy, but most recognised a genuine wish to celebrate one of this country's greatest institutions, even while we are in danger of losing it.

Talking about great institutions and sporting achievements, the award of Hero of the Year goes to my Co Chair Clive who distinguished himself by running from Nye Bevan's statue in Cardiff to the DoH in London, an unbelievable feat which required 6 marathons in 6 days. We salute him and his running partner Dr David Wilson both of whom spent a great deal of time in ice baths, although with or without added gin and tonic is not reported. They were helped along the way by the indefatigable Chris Burns Cox who provided transport, logistical support (and possibly the gin). Read about it at http://bevansrun.blogspot.co.uk/p/welcome-to-bevans-run.html

Hypocrite of the Year award was a difficult decision as ever but probably goes to the Coalition government for rubbishing the NHS at home while selling its brand abroad. But there were plenty of other contenders for the title.

The year has been a busy one for your officers, with many public talks, articles, letters in the paper and arm wrestling with more conservative institutions. Thanks go as ever to our equally indefatigable president Peter Fisher, without whom the organisation would not survive let

alone prosper, and to you, our members, whose subs allow us to help our sister organisations KONP and the NHS Support Federation in their important campaigning work. More members mean more money and perhaps if you do one thing to help the NHSCA in the next year it should be recruiting at least 2 new members. And meanwhile be thankful you're not running 6 marathons...

(1) http://www.guardian.co.uk/commentisfree/2012/aug/17/philip-hammond-light-privatisation-government?CMP=twt_gu

(2) http://nvl002.nivel.nl/postprint/PPpp4488.pdf

(3) http://www.guardian.co.uk/society/2012/jul/31/bankruptcy-criminal-record-nhs-roles?newsfeed=true

(4) http://socialinvestigations.blogspot.co.uk/2012/08/the-telegraph-think-tank-and-very-dodgy.html?m=12.8.12

(5) http://eoin-clarke.blogspot.co.uk/2012/08/21-nhs-hospitals-worth-15bn-could-be.html

(6) bmj.com/content/345/bmj.e5128?sso= …

(7) http://www.guardian.co.uk/society/2012/aug/12/nhs-private-carillion-sight-clinicenta

(8) http://www.nytimes.com/2012/08/07/business/hospital-chain-internal-reports-found-dubious-cardiac-work.html?pagewanted=all

JACKY DAVIS
Guest Editor

'Qualified providers': evidence from existing for-profit providers to the NHS

With the passage of the Health and Social Care Act private companies registered as Qualified Providers of health care for NHS patients are due to become a fast-growing part of the provision of NHS care. Companies that are already playing a significant role in the provision of NHS services – from general practices and out of hours care to residential care for mental health patients, community health services, and various forms of secondary care – are all expecting to expand their NHS business.

The government's rationale for the switch to private providers is that it will promote choice and efficiency. This paper reviews the performance of some existing corporate providers of NHS services to see whether the evidence supports this claim. The evidence suggests that (1) while corporate providers may compete for contracts, once they have one they have an effective monopoly (e.g. when Virgin Care became the sole provider of almost all forms of community health care to patients in Surrey). Patients play no role in the award of contracts and once they are awarded have no choice, as there is no other provider of the service within a practicable distance. (2) Company law requires company directors to maximise shareholder value. The 2006 Companies Act aimed (largely unsuccessfully) to extend their responsibilities to include other 'stakeholders', such as employees and creditors, but not to customers – i.e. not to patients. Corporate decision-making and the incentives of employees are ruled by this requirement. (3) Where this leads to cost-cutting or other measures that lower care quality it is liable to escape sanctions and rectification because adequate monitoring is too costly, and because the element of monopoly makes the ultimate regulator's weapon – the withdrawal of registration – virtually unusable. The operation of this logic is apparent in a series of recent cases.

The Practice plc.

In February 2012 The Practice plc, which runs some 40 GP practices and walk-in centres in England, announced that it was closing its Camden Road practice, one of its three practices in Camden, north London[1]. These practices had been first awarded to a private company in 2008, when UnitedHealth's offer to run them

for 30% less per patient than the GPs who were competing for the contract was accepted by the local PCT, even though the GPs had been judged to offer 'superior core services'. At the time UnitedHealth had no experience of providing primary care in England. It was widely believed that UnitedHealth was prepared to lose money on the contract in order to gain this experience and establish a position in the new primary care market. In April 2011, however, when the contract still had two years to run, UnitedHealth decided to leave the primary care market and concentrate on providing services to the new Clinical Commissioning Groups foreshadowed in the recently published Health and Social Care Bill, and sold the Camden contract to The Practice.

The owners of the building in which the Camden Road practice was housed were a GP and a manager who had run the practice before it was awarded to UnitedHealth, and they were now unwilling to renew the lease beyond April 2012. The option of leasing or even buying an alternative building does not appear to have been considered. The patients were to be redistributed to other (inevitably more distant) practices in the area, and all continuity of care was lost. At the time the firm was employing one locum doctor, with a second 'regular' GP for 'continuity of care', for the practice's 4,700 patients. Saving money on staff had begun in 2008 under United Health. Patients reported that UnitedHealth had immediately dropped two experienced doctors, that a third soon resigned on grounds of stress, and that there had been a constant turnover of doctors. It did not appear that any authority had intervened to challenge a damaging level of cost-cutting.

Several other features of the case are worth noting. One is that there were qualified GPs who would have liked to run the practice in alternative premises. But the government now requires new practices to be put out to tender. Rather than risk another private firm winning the contract and providing another sub-standard service, NHS North Central London thought it safer to place the patients in other existing practices, even if some of them would be hard for older patients and mothers with young children to get to. The Medical Director of NHS North Central London told a public meeting: 'Surely you are not asking us to go through another tendering exercise – are you? Be careful what you wish for. My experience is that other providers find it incredibly difficult to make a success of general practice.'[2] A second point is that patient choice played no part in the story. A third is that The Practice was allowed to walk away from its contract for the Camden Road practice, which still had a year to run[3]. In effect, the contract was unenforceable.

The PIP silicone breast implants affair

The 10,000 breast implants inserted in women in the UK every year are big earners for private companies, and for some NHS surgeons working privately. According to Naomi Wolf, an American specialist on the topic, 'The implant manufacturers' own literature warns that one in four women will need additional surgery within the first year after getting implants, and many will have multiple surgeries,' though women are rarely made fully aware of this[4]. Within ten years fifty percent of implants harden and rupture. The UK medical devices regulator, the MRHA, apparently saw no problem with this. In the US, in contrast, the evidence of the risks involved led to implants being banned for fifteen years.

In 2010 it was discovered that the French manufacturer PIP had been illegally using industrial grade silicone in its implants, which also tended to rupture sooner, leaking noxious substances into the chests of the women who had them – about 47,000 of whom were in the UK. The French government advised all women with PIP implants to have them removed, and prosecuted the former owner of PIP, which had gone out of business. The UK regulator, in contrast, advised women with PIP implants that there was no cause for alarm. The government reluctantly promised that any woman who wanted a PIP implant removed could have it done on the NHS, while trying to get the firms that had put them in to undertake to remove them. Some did, but others declined. For the patients treated by these firms the costs were met by the NHS.[5]

Here again we see the profit drive leading to cost-cutting at the expense of care quality, and inadequate regulation. It is worth adding that the US ban, imposed in 1992, was lifted again in 2007 following intense pressure from the cosmetic surgery industry. When the UK private sector becomes stronger, as is intended by the 2012 Health Act, we cannot expect the MRHA, which never imposed a ban, to be more effective than in the past.

Winterbourne View and Castlebeck Care

Winterbourne View was a private hospital near Bristol for 24 adults with mental disabilities. In May 2011 an undercover BBC reporter exposed the fact that the patients were being grossly abused. Fifteen warnings from members of the staff over the previous five years had been ignored by the local council and one by the Care Quality Commmission. Only after Panorama screened the violence being meted out to the patients did the CQC investigate. The Panorama programme found that specialist staff that had been promised had never been employed; too few staff were employed to run any activities for the patients except watching TV; most of the staff the hospital did have were essentially untrained and paid minimum wages; supervision was completely inadequate. The serious review report subsequently concluded that 'the majority of staff at the hospital were unregulated support workers who are not subject to any code of conduct or minimum training standard. It appears that over time Winterbourne View Hospital became a support worker led hospital'[6]. The hospital was charging the NHS £3,500 per patient per week.

It turned out that so far from being an extreme case, Winterbourne View reflected the business model and ethos of its owners, Castlebeck Care Holdings. When the CQC belatedly inspected 23 of Castlebeck's other 54 hospitals and homes the inspectors reported 'serious concerns' about four of them, while seven others 'were failing to comply with one or more essential standards'. The CQC then looked at the whole range of such services provided by Castlebeck and identified the following 'company-wide themes': 'lack of training for staff'; 'inadequate staffing levels'; 'poor care planning'; and 'failure to notify relevant authorities of safeguarding incidents'. [7]

This report is significant for two reasons. First, it was exceptional. Although in light of the Winterbourne View scandal the CQC now proposed to carry out unannounced inspections, its resources would not allow it to do these for all providers on even an annual basis. Second, the detailed findings of the report make it clear that Castlebeck's institutions were run on a bare minimum of staff (for example 'Length of shifts at Castlebeck services, meant that staff worked for at least 12 hours') and were rarely pleasant and not always safe places to be. According to Panorama, the company's profit margin was 37%.

Eleven members of the staff at Winterbourne View were arrested and pleaded guilty to a total of 38 charges of ill-treatment, the hospital's registration was removed, and it was closed in June 2011. The chairman of Castlebeck resigned, as, eventually, did the chief executive of the CQC[8]. But Castlebeck's other operations were not suspended. The CQC 'called on' the company to make 'root and branch improvements'. The scale of Castlebeck's operations made it impractical to threaten de-registration for all of them.

Southern Cross

Southern Cross was a provider of long-term care to 31,000 residents in 754 care homes in the UK. Before 2006 it was owned by an American private equity company, Blackstone. During the boom years Blackstone sold off all the buildings and leased them back from their new owners, making a large profit, and then floated the company on the stock exchange. Then came the crash. Cash-strapped local authorities started cutting the fees they would pay, and raised the threshold for judging people as needing full time care, so the demand for places also fell. Southern Cross had too much debt and not enough income and became bankrupt.

The government said that no one in any of the homes would be made homeless. It did not promise that no one would be forced to move. Eventually new operators were found for all the homes, which was fortunate, since old people moved from one care home to another often become disoriented and ill, and some even die with a few weeks of a move.

What is significant about this case is the way Blackstone's financially *efficient* arrangements put the welfare and health of 31,000 people at risk. It is understandable that the government was unwilling to undertake to keep all the homes going, even as a last resort. There are about 300,000 people in privately-owned residential care homes in England. If the government undertook to bail out any home that was at risk of closure it would be liable to pick up the bill for every bad business decision, or even misappropriation of funds, for which care home owners were responsible, as it has done with the banks.

But not giving this guarantee means that the security and welfare of the residents is secondary. Their homes can be bought and sold over their heads, with unpredictable consequences for the continuity and quality of management and staffing, and may even be closed. This is especially true of the 135,000 homes backed by private equity. For corporate care home owners the bottom line is that residents are an income stream, not people whose interests are paramount.

Discussion

It may be objected that these cases are all exceptional, and in the sense that they came to light and attracted publicity that is true. But the list of 'exceptional' cases of low quality privately provided services could easily be extended. The outsourcing of hospital cleaning, based on drastic wage cuts and work speedups, and its link to the MRSA and c.difficile hospital epidemics of the 1990s, have been well documented[9], as has the uneven and often inadequate for-profit provision of domiciliary care and long term residential care[10], the poor quality of some out of hours primary care[11], Netcare's early ISTC cataract surgery[12], etc.

But the point is not that these cases are typical. Most companies will be more concerned with their reputation than Castlebeck clearly was, if only for the sake of their long term ability to secure contracts and patients. Few will deliberately employ bad workers, let alone sadists, and few senior corporate officers are greedy sociopaths (though they may sometimes be). The point is rather that they operate under a different imperative from public sector staff. In the case of firms with shareholders, the owners have invested in them in order to make money, not to be part of the caring professions. Managers and staff working for these firms may wince at what they are required to do (or not to do), but they have no choice if it increases profits. That is what efficiency means to their employers and what UK company law requires. Company law doesn't say they must put patients' interests before those of shareholders. It says the opposite.

Regulation can restrain this logic to only a limited degree. The cost of really close supervision would be prohibitive. The history of the Care Quality Commission is one of far too few staff, with inadequate qualifications for the work, and weak leaders failing to insist on having enough staff to do serious inspections or to stand up to pressures to tone down negative findings.[13]

And the only real sanctions for poor private provision – punitive damages, or revocation of registration – can rarely be used. Damages are always liable be contested in the courts, making it too expensive to impose them. And removing a firm's registration is often next to impossible because of the risk of disruption to patients, and because large firms may also contest that in the courts.

NHS providers have hitherto been subject to a different logic, prioritising patient care. But as Foundation Trusts (which they must all become by 2014) they will increasingly have to follow the market logic of their competitors. They do not have shareholders, but they must compete with companies pursuing the cost-cutting, revenue-maximising policies which shareholders demand. They also have to cope with budget cuts and loss of income as services are unbundled and parcelled out to a range of new market entrants. Many of the recent instances of bad practice within the NHS – such as the widespread failure to give enough attention and respect to older patients[14], or the gross neglect of patients at the Mid-Staffordshire Hospital[15] – have been the result of cutting staff and giving priority to the financial bottom line. As the healthcare market expands, the imperatives and norms of the for-profit sector are bound to become increasingly general.

A further feature of companies that will qualify as providers of NHS care under the 2012 Health Act is their tax arrangements, which are also governed by the principle of 'shareholder value'. A study of five of the largest of them showed that they all minimise their tax liabilities in the UK through complex holdings in the Cayman Islands and other tax havens[16]. In some cases – for instance Spire, owned by Cinven (a private equity firm advised by the former Secretary of State for Health Patricia Hewitt), and Care UK, owned by Bridgepoint (another private equity firm, this time advised by the former Secretary of State for Health, Alan Milburn) – these arrangements have largely prevented any of their profits being taxed in the UK.

Colin Leys

(1) Tom Foot, 'NHS CUTS: no plan to open new GP surgery in Camden Road', Camden New Journal 16 February 2012, http://www.camdennewjournal.com/news/2012/feb/nhs-cuts-no-plan-open-new-gp%E2%80%88surgery-camden-road

(2) Ibid.

(3) The terms of the contract are commercially confidential but it seems likely that as with the contracts given to the first ISTCs, risk was assigned largely to the NHS, as the following remarkable statement implies: 'NHS North Central London said that the early 'mutual termination' of the contract would not involve any compensation payouts to the private provider.' ('Private firm closes flagship GP practice in north London', Pulse, 07 Feb 2012. http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/13395610/private-firm-closes-flagship-gp-practice-in-north-london

(4) Naomi Wolf, 'The silicone breast implant scandal', Guardian 15 February 2012, http://www.guardian.co.uk/commentisfree/cifamerica/2012/feb/15/silicone-breast-implant-scandal-naomi-wolf

(5) By mid April 2012 7,000 women had been referred to the NHS for consultation on PIP implants, most of them inserted by private sector companies. See Mark Gould, Onmedica, 13 April 2012, http://www.onmedica.com/newsArticle.aspx?id=23658aae-85e2-431a-a700-ef9e55f93bbb It also emerged that a Dutch implant manufacturer, Rofil, had sold PIP implants under a different name, and that some 5,000 women in the UK had received these (Fiona Macrae, Mail Online 5 January 2012, http://www.dailymail.co.uk/health/article-2082421/New-implants-warning-More-women-risk-suspect-silicone-sold-different-name.html

(6) South Gloucestershire Safeguarding Adults Board, Winterbourne View Hospital: A Serious Case Review, Summary p. iii.

(7) Care Quality Commission CQC Review of Castlebeck Group Services, 28 July 2011, at http://archive.cqc.org.uk/newsandevents/castlebeck.cfm

(8) The Chief Executive of the CQC resigned in March 2012, evidently to avoid being sacked for what had become an undeniable record of incompetence.

(9) Steve Davies, Making the connections: contract cleaning and infection control, Unison 2009, http://www.unison.org.uk/acrobat/14564.pdf

(10) The proportion of for-profit care homes rated poor or average by the CQC in 2010 was almost double the proportion of non-profits similarly rated: see see Sarah O'Connor and Cynthia O'Murchu, 'Britain's private care faces crisis', Financial Times 30 May 2011, at http://www.ft.com/cms/s/0/307bbd3e-8af5-11e0-b2f1-00144feab49a.html#axzz24IYbFKFY

(11) For a good survey of the nationwide problems of privately-provided out of hours care see http://www.dailymail.co.uk/health/article-2171173/Dozens-like-Kelsey-died-incompetent-hours-cover-GPs-So-safe-YOU.html#ixzz24HLP6tZp

(12) Stewart Player and Colin Leys, Confuse and Conceal: The NHS and Independent Sector Treatment Centres, London: Merlin 2008, pp. 45-46.

(13) The former chair of the Care Quality Commission, Baroness Young, told the Mid Staffs inquiry that she often encountered political interference to keep bad news out of the media and when CQC reports were found to be unfavourable, she was 'leant on' to alter or 'tone down' her reports so that they were less critical of the NHS. She eventually resigned in protest.

(14) Care Quality Commission Dignity and nutrition inspection programme: National overview, October 2011, http://www.cqc.org.uk/sites/default/files/media/documents/20111007_dignity_and_nutrition_inspection_report_final_update.pdf

(15) Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume I, Chaired by Robert Francis QC, HC725-1, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf

(16) 'An unhealthy business: major healthcare companies use tax havens to avoid millions in UK tax' Corporate Watch March 17, 2012, http://www.corporatewatch.org.uk/?lid=4251

Going private? My reply to a job offer from a private health company

What the heck is this? I've been trying and failing to stop the government from privatising the National Health Service for years, and now a private healthcare company has contacted me about a job!

The email from Care UK says they are "seeking a Media Relations Executive for our Head Office based in Colchester and your skills and experience appear to be a good match." Huh? They are offering a "competitive salary, 25 days holiday and corporate discounts."

Here's what I have replied:

Dear Laura,

Thank you for your unexpected email about the Media Relations Executive job with Care UK. I am very interested. Since Care UK is possibly the leading private healthcare company making inroads into the NHS, I would relish the opportunity to publicise what it does – indeed, this is precisely what I was trying to do in my previous job as information officer for Keep Our NHS Public (on a much smaller budget, I'm sure). That must be what you were referring to when you said my skills and experience are "a good match".

As you can imagine, I am brimming with ideas. If you don't mind, I would like to set them out here. First of all, I think much more needs to be done to let the public know what Care UK is. Hardly anyone realises just how big a chunk of the NHS you now run, from GP surgeries and walk-in centres to treatment units doing things like bunions. If I were your Media Relations Executor I would promote this aggressively to build the brand. I think the public has a vague idea about NHS privatisation, but they aren't yet able to put a face to the name, so to speak. *Care UK's name could be that face.* As a profit-making healthcare company owned by a private equity firm you are perfectly positioned.

I believe a key talent for any disrespecting Media Relations Executive is the ability to turn a negative in to something offensive. For example, it must have been a stressful time in the Media Revelations office when that tax avoidance story broke a few months ago – the one saying that Care UK had reduced its tax bill by taking out loans through the Channel Islands stock exchange. All this talk of tax havens and tax avoidance isn't good in the current climate. But as your Media Relationship Executive I would have used a little reverse psychology, instead of denying it as your spokesman did. After all, this could put you right up there with the big boys like Goldman Sachs, Vodafone and Jimmy Carr.

Similarly, you got some bad press when it was revealed that the wife of your former chairman John Nash gave £21,000 to Andrew Lansley's office before the last election, when Lansley was shadow health secretary. But let's view it from another angle – doesn't this serve to highlight Care UK's excellent political connections? And look how it turned out: Lansley is in power and he has passed the Health Act. He has opened the door wide to privatisation, and Care UK is already inside redecorating the place. We thought Lansley wasn't going to manage it for a while, when all those thousands of patients and doctors started protesting and June Hautot shouted "codswallop" at him in the street. But he pulled through, sacrificed his future public career for private gain, and God bless him for that. Care UK now stands to make a fortune. This is something to boast about, for Bevan's sake! And all for £21,000, less than it would cost to employ a Media Relations Executive for a year. (Please confirm).

You should play to your strengths. Care UK is a true pioneer in this privatisation drive. You were the first private company to run a GP surgery in Dagenham back in 2006. And the first to face enforcement action from the Healthcare Commission because of slack hygiene procedures at the Sussex Orthopaedic Treatment Centre in 2008. And who's to say you weren't the first to forget to process 6,000 x-rays at your 'urgent' care centre in North-West London in 2012? As a Mediocre Relations Executive, I would advise not mentioning those last two.

If there's just one thing that Care UK knows how to do – and there is – it's take money from the state. I would make a bigger deal of the fact

that 96 percent of Care UK's revenue comes from the NHS. That's the kind of solid base that any company would envy – taxpayers' money, minimal risk, easy profits. So shout about it! It shouldn't just be left-wing NHS obsessives who hear about this stuff.

Take the Barlborough Treatment Centre. It's a complicated story, but in the hands of a good Media Relations Excretion it can be turned into a wonderful example of the company's strengths. First, Care UK was paid £21.9 million over five years to do orthopaedic surgery – hip and knee replacements, that kind of thing – but you only did £15.1 million worth of work. (The local NHS Medical Director saw the trick, complaining: "The problem we have got is that they cherry-pick; they don't take any patients with complicated conditions". I guess the joke's on him.) The NHS eventually realised it was getting a bad deal, and things weren't looking good for Care UK. But then the NHS bought the treatment centre from you for £8.2 million, a lovely gesture. And finally the NHS signed a new 30 year contract to run the centre with… Care UK! (As an aside, it is important from a media management perspective not to spoil this tale of triumph-from-the-jaws-of-lucrative-defeat with any reference to the several lawsuits brought by local patients claiming that their surgery went wrong.)

As an example of what I could bring to the company I would like to propose a new corporate motto: 'Care UK – Providing less, for more'. These words came to me when I was thinking about Manchester, where last year the NHS paid you £2.7 million for work that was never done at your Clinical Assessment and Treatment Centre. According to a parliamentary report, the services you provide up there are between 7 percent and 12 percent more expensive than equivalent services in local hospitals. Providing less for more – it's a record that really ought to be publicised.

And Care UK should be proud of its talent for cost-cutting, like the plan to use more nurses and healthcare assistants in your GP surgeries because doctors are too expensive. Your managing director, Mark Hunt, describes this as "workforce efficiency on skill mix". As a Meddling Relations Executive I would advise him to ditch the jargon and tell it as it is. Patients might get a worse service, but at least the company is making more money and that's good for the economy. We're all in this together, as someone once said, in jest. I'm convinced that if Care UK followed my strategy it would solve the serious problem of patients accidentally opposing the private take-over of GP surgeries through confusion and surfeit knowledge, like when those blasted Keep Our NHS Public campaigners scuppered the Care UK health centre in Euston by threatening court action.

Be bold. Be proud. Be shameless. That's the approach I would bring to the job, and I hope you like my initial ideas. Please be sure to let me know when and where the interview will take place (the formalities must be gone through, I understand). I trust that I will hear from you soon.

Yours sincerely,

Alex Nunns

Book Review
Never again? The story of the Health and Social Care Act 2012

Nicholas Timmins. 148 pages. Institute for Government, London. 2012. Copies of the book can be downloaded free from: http://www.instituteforgovernment.org.uk

Nicholas Timmins is a senior fellow at the Institute for Government and the King's Fund. Had there been a declaration of interest, attention might have been drawn to the fact that the majority of the Institute for Government's funding comes from the Gatsby Charitable Foundation, one of the Sainsbury's Family Charitable Trusts. Of course the King's Fund is dependent on government and business

funding and has a history of advocating the integration of government and corporate policy interests. Its chief executive is Chris Ham and its board of trustees includes Simon Stevens, Julian Le Grand and Penny Dash.

Having commented on the messenger's affiliations, what about the message? This is a good book. Timmins describes the political antecedents to the Health and Social Care Act and its passage through parliament. He interviewed 30 politicians, special advisers, officials and other assorted players. He keeps confidential the names of his interviewees, because most of the book is critical of the Act. Many of the references he uses are to newspaper articles from the main broadsheets. The metaphors he uses to describe his story are "a political thriller" and a "car crash" though those that came to my mind were a train crash, the Second World War and autopsy findings at a coroner's inquest. The book reminds one in a highly readable way of the detailed history of the marketisation of the NHS.

Timmins has an easy style of writing with plenty of humour. As though his book were a theatrical play, he has divided it into five Acts, each with three to five Scenes. The title "Never again?" indicates that the legislation caused such ructions that the like of it should be avoided at all costs in the future. Jill Rutter of the Institute of Government has put out a document "Learning the lessons from 'Never Again?'" i.e. a commentary on the commentary, though she in fact also deals with the Act. She likewise accepts that the Act and its passage through parliament were largely disastrous and is in broad agreement with Timmins as to what went wrong.

Lansley had been shadow secretary of state for health for an unprecedented 6½ years before his party came to power. Within the Conservative party he had become his own health expert and more or less unchallengeable. When the transition to power and the formation of a Coalition occurred, the Tories' market in healthcare came up against the Lib Dem's manifesto commitment to democratic accountability e.g. of health boards. Over a three day period of Coalition amalgamation of health policy, there was a "cut and shut job" (this metaphor is derived from the process of welding together car write-offs in which the front of one car is welded to the back of a car of the same model – it may look alright but is potentially lethal). Department of Health officials who approached Lansley about unresolved tensions and contradictions in the bill found it was to no avail.

Timmins points out that nearly everything Lansley wanted to do could have been done without legislation. So why 550 pages which is three times the size of the 1946 Act? The current Act was to be Lansley's heritage, one that could only be reversed by further legislation rather than being subject to a new minister's redirection. Lansley had to re-define the working relationships of the components of the NHS. He rejected the argument that he was merely continuing the reforms originating from the white paper "Working for Patients" 1989 which were assiduously built upon by Blair, Milburn and Hewitt – had he adopted this argument he would have knocked the bottom out of a lot of the opposition that arose. A small piece of legislation could have made statutory the work of the Cooperation and Competition Panel set up by Blair which was in fact implementing European Union competition law. Lansley's approach to legislation was "carpet bombing" rather than "an accurately targeted rifle shot". The "emollient genius" of Earl Howe who presented the bill to the Lords was an important factor in facilitating its eventual acceptance there. Those who watched the Lords' debates on TV would have noticed what a smooth operator he is.

Timmins comments that the Act has wrecked at least in the short term the Conservatives drive to "detoxify" the NHS as an issue for themselves, that the Coalition has paid a huge political price and that this has been demonstrated in electoral polls. However, come the next general election, the £20 billion cuts to the NHS budget might have a greater electoral effect than the Act.

Morris Bernadt

Merger mania 2: the foundations of meltdown?

Introduction
From oral evidence to the Public Accounts Committee (PAC), 19 October 2011

Sir David Nicholson (CEO, NHS):
What do you mean by "district hospital"?

◆

Julie Lowe (CEO, Ealing Hospital NHS Trust):
[If we do not make FT status and] stay alone … we would get into a situation where we needed to be acquired by an NHS organisation that had achieved FT status. We are trying to get into a merger [with NW London Hospitals Trust] and then through an FT process so that we are able to achieve FT in a new organisational form. That would be our preference.

Joseph Johnson (PAC member):
In other words, a shotgun marriage with any institution that will take you, come 2014.

Julie Lowe:
That is one potential solution.

◆

Margaret Hodge (PAC Chair):
It seems that your strategy of viability depends on merging… There is a massive and completely unsustainable PFI at Barts... for £1.2bn. The only reason you're merging two failing hospitals – Newham and Whipps Cross – is to sustain the PFI at Barts. Rather than the stronger supporting the weak, the weak is being sacrificed to the PFI.

Sir David Nicholson:
…I can say that it's not being driven by the PFI. What it's being driven by is making sure that everyone in that part of London gets the best quality health care possible.

◆

Hospital mergers don't work. Other than a few well-planned individual mergers, for example the Oslo teaching hospitals, those based on economic or political dogma have never generated any meaningful benefit, however it is measured. The most rigorous study, published in January by Bristol University's Centre for Market and Public Organisation, based on English hospital mergers during 1997-2003 (half of the 223 total) concluded that there was no gain, even when analysed for 4 years after merger in order to exclude any acute effects (Box 1). The results will almost certainly be mirrored in the current mergers, though the vocal pro-merger lobby contends it will be different this time round. The Government and Department of Health have ignored the Bristol findings.

Box 1
Consequences of English hospital mergers, 1997-2003

- 12% annual fall in activity, staff and beds
- No change in operating expenditure
- Expenditure on managerial staff increased by 8% and on agency staff by 30%
- Any surpluses fell over at least 4 years
- No improvement in 'quality' measures eg waiting times
- No improvement in clinical measures (myocardial infarction and hip fractures); stroke outcomes worsened (but pre-stroke centres)

The new merger mania, 2009 onwards
New system risks NHS drowning in a tsunami of hospital mergers (Health Service Journal (HSJ), 29 March 2012)

English hospital mergers stopped after 2003, but there's no keeping down political dogma, especially when there is no evidence to support it. The 2009 phase kicked off with a deluge of community mergers that hospital doctors were mostly unaware of. The statistics are revealed in the website of the impeccably neoliberal Competition and Cooperation Panel (CCP), founded in 2008 to (among other activities) scrutinise proposed NHS mergers. Sandwiched between deserts of activity in 2009 and 2011, 2010 saw 16 community mergers and 22 between community and acute trusts. The CCP was evidently under pressure: nearly 70% of the mergers went through a 'fast-track' evaluation. Several were multiple mergers of baffling

complexity. The HSJ explains, plausibly, that this rush resulted from medium-sized trusts (turnover around £100m) not being permitted to apply for stand-alone FT status, at least not without the additional financial buffer of a community trust.

The activity is reminiscent of the frenzy of private sector mergers and acquisitions of the 1980s, but the motivation is pure politics:

> It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust and in due course, we will repeal the NHS trust legislative model (Health Act)

Under an aggressive and optimistic timetable, and with very few exceptions, all trusts are to become FTs by April 2014. However, by October 2011, 45% (113) had not yet made the transition. The pipeline for approval is likely to be congested and possibly chaotic, though with 18 months to go, nobody has signalled any slippage. Monitor has already complained to the Health Select Committee about the number of late applications.

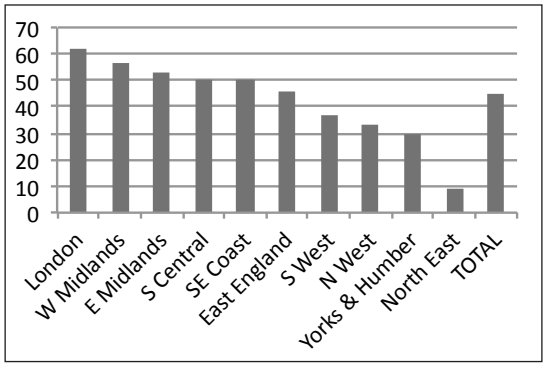
The situation is a classic example of disaster doctrine where doctrinaire imperatives result in catastrophic breakdown that can be resolved only by employing even more drastic – and nearly always market – 'solutions', in this case a merger spiral. Exploitation of historical accidents and the unexpected are critical: in this case likely further changes to the FT application process resulting from the Mid Staffs (Foundation) enquiry, due shortly; the effect of mandatory annual 4% cuts; and the ubiquitous and baleful presence of management consultants who unsurprisingly uncover failures for which they fortunately have just the right remedies (for example in London, where McKinsey found that 6 of 22 London trusts with PFIs were nonviable). About 60 trusts, unable to complete FT applications before April 2013, will find themselves under the watch of the recently-formed NHS Trust 'Development' Authority (NTDA), whose task, far from 'development', is to consign trusts to history in record time. Sir David Nicholson outlined the usual dreary litany of 'remedies' to a sceptical PAC: external management teams; operating franchises; mergers or acquisitions; and instances where the secretary of state would order compulsory takeovers or mergers.

Panicked acute trusts have understandably rushed to merge. In March, 60% of acute trust CEOs were considering some form of merger. Interestingly, the majority of merger proposals currently with the CCP (**Box 2**) are not in London, reflecting the fact that although London is relentlessly demonised as a unique basket-case of financial and clinical incompetence, it is only by a slim margin the least-foundationed of all the English regions (**Figure 1**). The paragon of the north east (territory of Sir Peter Carr, NDTA chair) will no doubt spread to the unreconstructed south.

Box 2
Proposals for acute mergers with the CCP (August 2012)

- Winchester & Eastleigh with Basingstoke Foundation
- Ealing Hospital with NW London Hospital Trust (neither are FTs)
- Trafford with Central Manchester Foundation
- Scarborough & NE Yorkshire with York Teaching Hospital Foundation
- Dartford & Gravesham (Darent Valley Hospital) with Medway Foundation (Dartford & Gravesham has the highest English PFI burden – 20% of turnover)
- Northumbria Healthcare Foundation (acquisition of) N Cumbria University Hospitals
- Epson General Hospital and Ashford and St Peter's Hospitals Foundation
- Royal Ear, Nose and Throat Hospital (Royal Free Hospital) and University College London Hospital

Figure 1
Percentage of trusts in the FT pipeline (NAO: October 2011)



The threat of the supermerger

We are likely soon to enter a phase of leapfrogging acquisition mania. The CCP will offer little resistance (even if it did, the Secretary of State is not obliged to take its advice). The process is self-fulfilling: the CCP can take only the narrowest view of the effect of mergers on competition and their potential to reduce patient choice.

The playing field is level only for unfavoured organisations. Over the course of the loans, PFIs will have access to a bailout fund reputedly of £1.5bn; capital reserves of some struggling trusts may be strengthened by loans totalling £376m; and no doubt all manner of deals are being struck of which we are unaware. (The CCP disclosed that Barts and The London were given around £50m of transition funding to cover the costs of transferring to their new PFI, though nobody would rescue my currently viable trust to the tune of its historical £30m debt. Naturally it will be repaid immediately we become a foundation.)

There is some evidence for the self-reinforcing scenario. In April the largest ever NHS merger, orchestrated by Ernst & Young between my trust (Whipps Cross), Newham, and Barts and The London slipped through almost unnoticed by the media, professions, or the people of east London, who were consulted in the usual minimal just-in-time way that serves primarily to forestall challenges on the consultative process. All three are financially challenged with their own reasons for merger: Whipps Cross through its historic debt; Newham and its current deficit; and Barts and The London, as Margaret Hodge pointed out, will toil for more than 30 years paying off our £1.2bn PFI debt at £60m or more a year. In line with older analyses showing that finances deteriorate immediately after merger, in the first three months we are £8m further in debt. Accordingly, our Tripartite Formal Agreement, the mandatory foreplay to FT acceptance, now has red status and we will undoubtedly come under the NTDA regime. Nevertheless, our medical director maintains there will be huge savings on 'back-office' functions, through reducing waste and duplication (including job losses, already proceeding vigorously), and increased buying power, though we will need pretty generous discounts to save £60m a year. According to the CEO of Winchester & Eastleigh, which has 'chosen' to become a 'foundation trust by acquisition', the savings menu includes 'consolidation' with partners to 'account for future clinical developments', 'subspecialisations', and the needs of junior doctors' rotas. Senior doctors will also be in the frame: in mega-merged trusts there are potentially massive savings by salami-slicing job plans. There is also, inevitably, 'estate rationalisation', that is programmed death of old estate through neglect. We have heard these ritual declarations countless times, and one doubts the outcome will be different this time. Sadly, the east London rhetoric didn't end with back-office fantasies. We heard the extravagant claim that 'the merger will give our doctors, nurses … the opportunity to raise life expectancy and the quality of life for many, many thousands of our patients and revolutionise healthcare across east London'.

In fairness to the CCP, it tried resisting the charm offensive. Right up to its final reluctant admission that the merger process had gone too far to stop, it expressed concerns about its fundamental viability. It cannot make recommendations on clinical grounds (there is a clinical reference group, but it does not publish its deliberation); however, reading the extensive if impersonal analyses I was impressed at the incredulity with which it managed to respond to many of the trusts' overblown claims.

But there is now a political precedent. An unworkable mega-merger reassuringly generated little political impact. No local MPs expressed more than token reservations; some, not all Tory, framed brief, craven notes to the CCP urging no further delays. Neither was there meaningful public reaction: the chair of Whipps Patients Panel supported the merger almost without reservation, and although Newham LiNK – successors to the ferociously independent English Community Health Councils, disgracefully abolished in 2003 – registered concerns, no other local health-related bodies bothered to express a view. At the time, public health was itself in the middle of a colossal change and was in no position to take any view other than the corporate line. No doubt emboldened by east London's easy ride, three south London FTs (King's, Guy's and St Thomas's, and South London and Maudsley) recently proposed an even bigger merger (£2bn turnover), and London may soon only have three medical schools and their associated mega-merged clinical empires. England will fairly soon only have 40 FTs, all, naturally, too big to fail.

The end of the District General Hospital

Finally, what of the DGH, which the NHS CEO no longer recognises? Actually, its fate was sealed by Patricia Hewitt in the mendacious 2006 paper 'Our health, our care, our say', which attributed the state of NHS finances to profligate hospitals. Since then many individuals and bodies, including royal colleges, have parroted the rhetoric of DGH demise. In their place will be the new healthcare duality: world class superspecialist centres (a major fantasy selling point for the east London merger – everyone will have access to their local professors), and community services that will pick up everything else. But an astute PAC member, Richard Bacon (Conservative) pointed out that health interactions don't divide up quite so neatly. When the English DGHs finally collapse, what will become of the septicaemic 45 year old with multi-organ failure who can't be moved to the nearest ICU 20 miles away because she's too ill and may die in transit?; who will manage the compound fracture when the regional trauma unit is overwhelmed and there's no experienced orthopod around?; who will diagnose the sick person who has exhausted all the protocols of a minor injuries unit (if they're even recognised as sick)? And will anyone be able to keep at bay the slavering multinationals and ultra-cheap pathology services when the contracts are so tempting? Little public detail is ever available, but a recent procurement dispute referred to the CCP involving a case brought by the private laboratory TDL against King's FT, quoted a pathology contract worth £300m; well worth fighting for.

What Hewitt and her anti-DGH bullies started, Foundation trusts and their associated forced mergers will neatly finish off well before the 20th anniversary of the 2000 Act. A nation happy to shop in only four supermarket chains might not be quite so comfortable with minimal choice of local medical provision and the mirage of a professor coming to their clinical rescue.

David Levy

References are available from the author: DavidLevyDM@gmail.com

From NHS to the national Serco service

With the pace of privatisation, soon we'll be depending on whistleblowers to monitor NHS services.

A clinic in Truro run by Serco for NHS Cornwall Primary Care Trust: 'The Serco story is a reminder of how quickly privatisation is progressing – though it is not always apparent as the private sector operates as part of the NHS family.'

The coalition justified bulldozing through the health and social care bill with the mantra that the private sector would deliver the service better and more cheaply. However, the bill's opponents were not surprised at the news that Serco, a leading private health company, was being investigated over an accusation of running an "unsafe" GP service. (Serco and NHS Cornwall primary care trust deny that patient safety was ever put at risk.) Serco, described as the company running Britain, delivers outsourced transport, detention, defence, education and now health services on behalf of government and local authorities. It has even been awarded a contract to run a first-point-of-contact service for the British Medical Association, some of whose members are likely to become – if they are not already – Serco employees.

Serco, contracted to run OOH (out of hours) GP services in Cornwall, has been accused by employees and MPs of having too few staff, resulting in long queues of patients for telephone advice and triage. Serco points to surveys that suggest high patient satisfaction with their service. It is also alleged that data and logs were manipulated to make it appear that Serco had met quality standards; but Serco says these allegations are not new and have been rejected by an independent audit. The Care Quality Commission is investigating, but we may never know the truth.

One casualty of the "reforms" is a sharp loss of public accountability. It will be increasingly difficult to penetrate the screen of "commercial confidentiality" that protects the private sector, which has moreover been exempted from

having to comply with freedom-of-information legislation. And staff transferred to private providers have little incentive to expose problems as DoH guidelines on whistleblowing will not apply to them. Serco has already begun an investigation of emails to trace the "leak" – to protect patient confidentiality, it says – despite having previously promised greater accountability in delivering services.

It is a fallacy that public services are better delivered by the private sector. Staff costs account for a significant slice of the NHS budget, and private companies will naturally seek to reduce them by cutting staff, downgrading them or both. In January Serco was criticised by the Royal College of Nursing for proposing a 40% cut in the number of nurses in its OOH service. The local PCT said staffing levels were an internal matter for Serco as long as patient care was not affected.

Elsewhere GP practices taken over by private companies have seen nurses replacing doctors, consultation times cut and fewer specialist referrals. A director of Deloitte's UK Centre for Health Solutions says that face-to-face GP consultations, the cornerstone of primary care, are no longer sustainable and urges GPs to adopt new business models and incentives. The language of the market, of consumers rather than patients and GPs as "care navigators", is increasingly familiar as management consultants like McKinsey take over as NHS gurus.

The Serco story is a reminder of how quickly privatisation is progressing – though it is not always apparent to the public as the private sector operates under the NHS logo and is cosily embraced as part of the "NHS family". Virgin has a role in rewriting the NHS constitution, and Virgin partners on commissioning groups will be responsible for spending £60bn of NHS funding. Serco has a community health contract in Suffolk and is in dispute with unions over a hospital contract in Plymouth. Both Virgin and Serco are shortlisted for children's services in Devon, the contract to be awarded to the "most economically advantageous bid", and those awarding it will no doubt bear in mind the fact that after losing a similar contract Virgin took NHS York to court, accusing the NHS bid of predatory pricing – ie not charging enough for services and so not being intent on making a profit.

Under Andrew Lansley's act organisations like Serco, "the biggest company you've never heard of", will increasingly deliver NHS services. The Care Quality Commission can't monitor all private sector involvement, as the Bristol care homes scandal showed, and we are likely to see more cuts to staff and services, less accountability and transparency and more scandals. We will have to rely on whistleblowers, the media and an alert public to know when things go wrong. The fight for the NHS is not over.

Jacky Davis

(This article was first published in the Guardian on 28th May2012)

Recruitment Strategy

Numbers in the Association have increased slowly but steadily and we now stand at over 700, drawn from all parts of the UK and representing a very wide range of specialties.

Our methods of recruitment have rested largely on sending individual letters with our literature (Information leaflet, policy statement and application form) to all consultants in every hospital on a rolling basis, averaging once every 5 years. To supplement this there are targeted mailings to those who have given some indication that they might be interested.

The Executive Committee has recently felt the need to review this strategy as to whether it is cost-effective. The immediate trigger was the enormous rise in postal costs. As a result of that we have now hired a franking machine which has brought significant savings.

The second factor is the fluctuation in response. Those who study the back page of the Newsletter will see that the number of new members varies considerably, largely with how much the NHS is in the news. During the protracted efforts to stop the Health & Social Care Bill becoming an Act there was a great deal of interest in the media

and within the medical profession. NHSCA and its views received publicity and of course there was opportunity to identify possible new members through their contributions to medical and lay press, their support for multi signature letters and petitions etc.

Our numbers increased well during this period but growth has slowed in the last 3 months. This is likely to be due to the Bill having finally become an Act and perhaps the feeling (quite erroneously) by some that there is little more we can do. It is the summer (more or less), parliament is in recess and there are holidays and many other events to occupy our attention, like the London Olympics and Paralympics.

For all the above reasons we have had a rethink and decided that although the routine recruitment mailings will continue, perhaps modified a little, there is no doubt that it is far more cost effective to make targeted approaches. **This is where we need your help.**

We appreciate that as in any large organization, the active members are in a minority and this applies particularly to one like ours where geography and clinical commitments make such things as attendance at meetings difficult for many. There are however easier ways to contribute. We all discuss things with colleagues in our work place, read journals and newspapers, look at websites and blogs, maybe use social media.

What we are asking is that if you come across someone who might hold our views you let us know by email, to nhsca@pop3.poptel.org.uk. For consultants the name is probably sufficient if an unusual one, otherwise the specialty and/or geographical area is helpful. Colleagues other than at consultant level are more difficult to identify so we would need workplace.

If you would like us to mention your name when we make the approach we can do so but unless you give us permission we would not reveal the source.

I very much hope that you will feel able to support our work in this way

Peter Fisher

Our professional bodies should stop opposing assisted dying

The BMA and some royal colleges are publicly opposed to legislation to permit assisted dying for terminally ill mentally competent adults. It is not the place here to rehearse what we, as members of Healthcare Professionals for Assisted Dying (HPAD), believe is the powerful case for such legislation, but rather to argue that the proper stance of our professional bodies should be one of neutrality.[1] HPAD was founded by Ann McPherson and her friend Professor Joe Collier in 2010 to challenge the stance of the medical establishment.

Medical bodies' stances on assisted dying

Opposed

- BMA
- Royal College of Physicians of London
- Royal College of Surgeons of England
- Royal College of General Practitioners
- Association of Palliative Medicine

No position

- General Medical Council
- Royal College of Anaesthetists
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians of Edinburgh
- Royal College of Surgeons Edinburgh

Neutral

- Royal Society of Medicine
- Royal College of Nursing
- Royal College of Nursing Scotland
- Royal College of Psychiatrists

At the heart of the case for neutrality is that the decriminalisation of assisted dying should be a matter for society as a whole to decide, and no particular group should have disproportionate

influence on this decision. The view of society is clear: the respected British Social Attitudes series, which uses representative samples of the UK population, has consistently shown that more than 80% of the general population, including 70% of those with religious beliefs, support assisted dying.[2] This is not an unthinking or ill informed response: support for assisted suicide for people who have severe illnesses but are not terminally ill is much lower, at about 40%.[3] Our professional organisations, committed to shaking off the paternalism of the past, should not use their influence to impose the beliefs of some of their members on patients: this is inconsistent with the idea of patient centred care and the principle of "no decision about me without me." The analogy with the opposition of the medical profession to the death penalty, which may be at odds with majority opinion, is flawed: those who want to bring back hanging are not asking for execution for their loved ones or themselves.

The publicly stated opposition of some medical bodies to assisted dying has been cited by many opponents of a change to the law, but this ignores the division of opinion within the professions, as shown by the fluctuating positions adopted by bodies such as the BMA and the Royal College of Physicians, which have been neutral in the past. The most reliable information suggests that between 30% and 40% of doctors are in favour of decriminalisation,[4 5] and the result of a recent survey found that a clear majority of doctors think that medical bodies should be neutral. Their voices have been silenced: they are not being represented by their representative bodies. It is interesting to speculate why this should be so: it is possible that those opposed to assisted dying have been over-represented in forums where the matter has been discussed, often because they are supported by well organised groups affiliated with religious institutions.

The primary grounds for the BMA's opposition to euthanasia and assisted dying are that it is alien to the traditional ethos and focus of medicine.[6] Secondary reasons are related to patient safety and a detrimental effect on societal attitudes and the patient-doctor relationship. The monstrous cruelty of walking away from a dying patient who is suffering unbearably seems more obviously contrary to the ethos of medicine. International experience has shown that placing assisted dying within the framework of the law would increase, not threaten, patient safety and have an entirely beneficial effect on trust in doctors.[7 8 9]

Individual healthcare professionals, as responsible citizens, are of course entitled and perhaps obliged to express their views on the ethical and clinical case for or against, and the potential social impact of, a law to allow assisted dying for terminally ill people. Doctors' representative bodies, however, should be confined to speaking about those areas where they have an expertise that goes beyond that of the general public - for example, advising on the necessary safeguards and codes of practice should any law be passed, and on matters such as assessing prognosis and setting guidelines for optimal end of life care.

Given the overwhelming support for assisted dying in society as a whole - and given also that there are healthcare professionals of good will, different faiths, and expertise in palliative care, with passionate views on both sides of the debate - we believe that the proper stance of healthcare professional bodies is one of neutrality. Members of HPAD therefore ask the BMA and those royal colleges that have declared themselves opposed to assisted dying to reconsider their position.

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Social enterprise – the issues

As part of a small community trust, co-terminus with a Unitary Authority, in 2010 it seemed that the obvious option was to become a "social enterprise" Community Interest Company. This was said by the management to be the real only alternative – as Foundation Trust status was unlikely as we were too small and integration with the local hospital Foundation Trust was felt to be not likely to be accepted and could affect community services – although I always argued that this was one way that issues became "our" problem rather than a constant blaming of other services. The CIC would also encourage staff to become involved as shareholders - like John Lewis!

However as time goes by there appears to be flaws in this brave new world – flaws that reflect the changing and disintegrating NHS. For instance:

- Over 15 months on new staff joining the CIC are not able to continue their NHS pensions. This has discouraged recruitment at more senior levels – where people have a larger investment in the NHS pension. A consultant post was advertised in palliative medicine and there was not even a single expression of interest, apart from a recruitment agency. All independent hospices have the agreement to continue NHS pensions and so this consultant post is one of a handful in CICs where this anomaly occurs.

  Moreover it now appears that Foundation trusts continue to offer NHS pensions and even Virgin Healthcare is able to do so as it takes over providing services in Surrey. This seems to be far from a level playing field and although change is promised the anomaly continues – and private companies seem to be advantaged over previous NHS organisations.

- The CIC has understandably started to build up a reserve fund – so that crises can be coped with – such as a commissioner failing to pay and the need to provide salaries even if there are delays in income. However this

does mean that £1.5 million – of the total £50 million turnover- is now in a bank account and not providing care for patients and the community. Although in the past any underspend may have been returned to the PCT it would have at least been used within the NHS. With all the CICs in England a large amount of NHS money, which in the past would have provided care, is locked up doing nothing! The NHS reforms were supposed to release funds from administration and management for patient care?

- As the CIC only has 2 consultants and an associate specialist, as well as directly employed GPs, medical staffing has been stretched in their knowledge and expertise, although they continue to improve. We have looked at the local hospital Foundation Trust Medical Director becoming our "Responsible Officer" but months go by without agreement on how this will work and be funded.

  We were also unable to be involved in the recent industrial action as the BMA had not informed the CIC of the dispute, although we had updated our details with them. It seems that even our union is struggling with these changes.

- There seem to be countless occasions when the NHS has not foreseen the effects of CIC status. We have been unable to produce and ratify our own Patient Group Directions, as a CIC cannot legally do thus. This has to be via the local NHS Commissioners.

I fear that our experiences show the real issues of the NHS reforms – rushed planning with little forethought and limited thought of all the implications of change. Be warned, wherever you work you may face the same chaos and uncertainty. We are probably too late to stop the relentless disintegration of the NHS and the loss of the coordinated care for patients and families, but can we at least encourage all involved to plan ahead and ensure the implications of change are foreseen and planned for.

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The AGM and Conference 2012

is being held on Saturday 6th October at

Friends Meeting House Euston Road, London

Invitations to the events, with application form, were posted to all members on 21st August but if any have gone astray further copies can be obtained from the address at the foot of this page.