NHSCA

EDITORIAL December 2010

A new government, led by Tories but tempered, we hope, by a sprinkling of Lib Dems. A White paper which contains a few welcome ideas like turning to a "bottom-up" approach to running the NHS. Professionals, including doctors, and patients are identified as at the bottom. No change there, then. If the views of frontline workers are to be valued, how will they be collected? As far as doctors are concerned the BMA and Royal Colleges will be most influential but others including our own Association must have a say. The pre-election stance of the BMA was encouraging but it seems to have weakened and the chances of getting a strong pro-NHS and anti-market stance seems less likely. The RCP may be more forthright under its new President but the other Colleges need also to be heard.

There are going to be financial pressures on services. One valuable contribution to the economy would be to save money on prescription drugs. Prof Richard Lachman (BMJ 16th October 2010) points out that it costs millions of pounds to develop a novel drug and can take up to 10 years. He suggests that cutting out phase III trials, which need large numbers of patients, would make new drugs cheaper and available sooner. Postmarketing surveillance should identify the uncommon side effects. He also points out that making better use of expensive medical facilities – including operating theatres, imaging equipment, pathology services – by making them available 24 hours a day, 7 days a week, would reduce capital expenditure and perhaps the need for new hospitals. It would also remove some of the risks of being taken acutely ill or being born "out of hours".

More staff would be needed but it should still give large economies and improvement in clinical care.

A statistic from the RAND corporation is that on average between one third and a half of a person's lifetime healthcare expenditure is spent in the last six months of their life, whenever that occurs. This suggests that no advance in medicine can do more than postpone the expenditure. The answer may lie in reducing expensive interventionist methods, often undignified and painful, when there is no prospect of appreciable gain in QALYS.

Implementing changes in these areas would allow healthcare expenditure to be better contained, unlike tinkering with management structures which is, he says, like rearranging the deckchairs on the Titanic.

If only constructive and important suggestions like the above were accepted by Government, benefits would accrue. Instead we have friction between professionals and the executive which fritters away time and opportunity.

In the same issue of the BMJ, Danny Ruta (a Director of Public Health for Lewisham) advocatess that GPs take financial responsibility for their budgets, legally enforced. He also accuses providers of acute secondary care of "inducing demand for services", pointing the failure of many attempts to control this over the past few decades. He sounds like a man with a consultant phobia, but you can't deny that thinking about the cost of clinical decisions should be part (but not a big part) of clinical training and practice.

In one of his regular and usually excellent BMJ pieces "From the frontline", Des Spence, a Glasgow GP, bemoans the increasing trend to narrow specialization, as he sees it. He thinks this is harming clinical practice by breaking down continuity and fuelling internal referrals which waste time and resources – a few years ago the generalist would cope with many cases which are bounced from consultant to consultant. Referrals to ultraspecialists are best made by secondary care doctors who will make fewer inappropriate referrals .

The above are some random thoughts on economies that could be made in the NHS as it now exists. They are insignificant compared to the sums involved in switching (again) to GP consortia and commissioning. The discussions on the White Paper from our AGM and some excellent ideas on possible action are available in the Minutes as described elsewhere in this Newsletter. The article by Anna Athow in the September 2010 Newsletter highlights some lesser-known and unpalatable facts.

- Foundation Trusts are almost certain to "overspend" if they treat every patient presenting to A & E and outpatients. This might get them labelled as a "failing trust", liable to takeover by a "successful trust" (nearby, one supposes) and loss of services to the local population.
- Trust mergers will be made easier.
- It will be easier to keep any surplus raised, i.e. behaving like a private, profit making business
- They will have to select "service lines" which are profitable and stop offering services which are not.

The work by Stewart Player, commissioned by NHSCA , entitled "Reshaping the NHS and its implications for consultants" is referred to elsewhere. The synopsis contains some very alarming sections:

- The consultant role will be remodeled in the "new NHS". Entrepreneurial skills will be encouraged; consultants to have independent status, in a transition to "managed medicine" (Kaiser Permanente model- judged not transferable, even within the USA.)
- Restructuring the "new NHS"
  - competition, choice, commissioning
  - further breakdown of hospital consultant power, "communitising medicine.
  - Decoupling from NHS institutions by formation of clinical networks, chambers, (I recall some support for these, mainly from surgeons, at BMA CCSC meetings 15-20 years ago but never thought they would be encouraged by government!)
  - Transition from institution –centred to problem-orientated structures (ISTCs for individual diseases?)
- Empowering insurance medicine

I do not know how many of these ideas will be taken up by the coalition government but even if a few are, there will be great difficulty in maintaining the principles of the NHS. Successive cadres of politicians have embarked upon "reforms"; very little of use has resulted but much confusion and discouragement. They never seem to understand that the NHS model is unique and precious and disappearing fast. The work of the NHSCA, KONP and the NHS Support Federation is much needed to fight these changes and to explain the implications of the White Paper to the public.

We should all support these efforts.

ANDREW PORTER
Paediatrician
Guest Editor

THE AGM AND CONFERENCE 2010
AT BEDERN HALL, YORK

The reports presented and write-ups of the contributions from our speakers follow.

Some last minute adjustments had to be made as unfortunately Evan Harris had to pull out at short notice and there was a little difficulty with timings due to another event at the Hall but all worked out well in the end.

Certainly those present seemed to regard it as very successful.

The Minutes of the AGM have been sent to all those who attended but are also available to any other member on request.

Elsewhere in the Newsletter (either in the text or as an insert, depending on space) you will find the names and contact details of the Executive Committee for the coming year.

The new Committee had its first meeting on 17th November and elected Officers

Chris Burns-Cox had asked to stand down as Co Chair because of other commitments and was replaced by Clive Peedell, others unchanged

Co Chairs Jacky Davis and Clive Peedell

Hon Secretary Malila Noone

Hon Treasurer Jonathan Dare

One other change to report is that management of the website has been taken on by Mark Aitken to whom suggestions for additions, deletions, other changes etc should be made. aitken.petri@btinternet.com

Peter Fisher

CO-CHAIRS' REPORT

The chief work of the past year has been responding to the government's doctrine of continued marketisation of the NHS despite overwhelming evidence that a market does not improve healthcare and increases costs by over 10%. The BMA has been staunchly against the market and Hamish Meldrum gave a powerful speech at the Public Services rally in Trafalgar square on the 10th April. There was an NHSCA contingent at the March with our very own banner.

Jacky Davis and Anna Athow are on BMA Council and strongly promote our views. Clive Peedell is also on Council and the BMA political committee. At our suggestion the BMA hosted a round table discussion "NHS beyond the Market" (see agenda item 10).

The immediate challenge is the NHS White Paper with policies that will in effect mean that the English people will no longer own their NHS which will be owned by private enterprises. The NHSCA is trying to enable the many disparate groups campaigning against these changes to work together. It is unfortunate that the BMA now appears to be in danger of tolerating the proposals in the White Paper.

We have worked closely with KONP and the NHS Support Federation and supported them financially. Both organisations are very active and influential

The EC has met five times at RMT Union headquarters and we are very grateful to them for permitting us to use their facilities. The four newsletters produced have been interesting and informative – the current September issue having outstanding contributors and contributions. They are on our website and should be more widely read.

The membership has remained at around 700 with 24 new members.

We are grateful to Malila for undertaking the role of honorary secretary.

As before, Peter Fisher has been the backbone of the NHSCA and Jacky Davis and Harry Keen are among the lead campaigners.

We are confident that although we have not been fully successful in achieving our objectives, the NHSCA has functioned according to the reasons for its existence and will continue to do so.

We encourage all members to visit the website frequently and send suggestions for improving it. To keep us in touch, the EC needs input so send us your thoughts, ideas and complaints.

JACKY DAVIS CHRIS BURNS-COX

Co-Chairs

HONORARY TREASURER'S REPORT

As far as the Honorary Treasurer is concerned this has not been a very significant year, unfortunately the same cannot be said for the politics of the NHS. The President and I continue our "chasing up" of members failing to pay their annual subscription with varied success. This has been a slightly better year in terms of recruitment of new members but that compared only with the depths of 2009! It can be seen from the accompanying audited accounts that Subscription Income is unchanged.

Against all precedents I am appearing at successive AGMs to speak to the Accounts which means the President is relieved of this onerous duty for two consecutive years! He does, however, continue to keep the finances flowing during my long sojourns in France. The Auditor Mr. Bob McFadyen has, once more, kept our accounts in impeccable order as witnessed in his accompanying report, again produced against a tight schedule.

In overall terms the accounts show one major change in that this year we completely spent our income after several years of slow accrual. This is consequent on our regular quarterly £1,500.00 support to KONP and extra contributions to the NHS Fed. This has continued in the present financial year with quite significant expenditure already made opposing the ConDem's NHS White Paper. It is for the AGM to decide if they wish this policy to continue.

The following points will help clarify some of the issues arising from the accompanying audited accounts:-

1} At only £300.00 the net cost of the AGM in 2009 was considerably lower than the two previous years. Unfortunately smaller attendance makes it look as though that figure will be very much greater this year.

2} The "Other Income" increase relates to a one off refund so will not happen again!

3} All other expenditure shows a remarkable consistency indicative of the sort of tight financial control by the NHSCA Treasury Team that would gladden the heart of the ConDems!

I would be very happy to clarify any aspects of the accounts that members find unclear.

Jonathan Dare

Honorary Treasurer, NHSCA

Fed launches campaign NHS SUPPORT FEDERATION to oppose the White Paper

The threats of the new White Paper demand an urgent public campaign. The Fed aims to alert and encourage organisations and individuals to join in opposing the proposals.

The Fed's campaign has attracted the support of 10 big unions, charities and patient groups

Our online e-petition is drawing support from all parts the community. The Fed is bringing together groups that want to collaborate. Our refurbished website (www.nhscampaign) summarises the case against the White Paper and passes online resources to campaigners.

Finding the evidence to highlight mounting privatisations

The first year of our major research project mapped the privatisation of NHS services. Details of outsourced contracts are not held centrally. We display to the public how services are being transferred into the private sector at a gathering rate.

Our first published report (see website) on our data showed how the growing takeover of GP surgeries by profit-making companies . The report also analyses the business strategies of the18 companies which control 223 surgeries and health centres in England. After this baseline year of data for outsourced primary care services, we are now focusing upon community services. (Supported byUNISON, BMA and NHSCA)

Protecting our NHS in Parliament

Before the election we launched our "Want my vote" campaign. This made politicians aware of key facts on NHS commercialisation.
Members contacted their MPs using the internet links and templates we had provided.

We have mounted a similar but larger effort showing the level of concern at the White Paper. We have offered to assist all the major trade unions in recruiting their members to emphasise to their MPs the public concern about the threats of local NHS privatisations.

In preparation for the forthcoming NHS Bill we have produced a briefing for the strategically important Lib Dem MPs. We are appeal to them on the grounds of the organisational upheaval, considerable costs and the implementation problems and resort to for-profit private companies that will inevitably follow the introduction of key plans like GP Commissioning.

With the backing of the health trade unions, we are actively exploring the organisation of a mass public parliamentary lobby. Volunteers in our campaign have prepared background information on the voting patterns and campaigning interests of MPs ahead of a programme of face to face to lobbying.

Putting health in the headlines

This year the Fed has provided comment and prompted health stories across the national and local media. It has recently achieved coverage in the Guardian, Daily Mirror, on Radio 4, and in the BMJ on the impact of the unmandated Lansley reform proposals.

We are working on a number of proactive releases - the next aims to prompt news coverage on the flawed claims of the health secretary to be able to save the NHS money through his reforms

We are also hoping to expand this area of our work by raising funds for a dedicated press and research function. Local media provide a huge, underused opportunity to raise NHS issues. We have been distributing our press statements widely with big increases in coverage in local papers and the numbers of local media interviews requested.

The NHS will only survive as long as there are people to fight for it

Echoing Nye Bevan's words the Fed laid out its plan earlier in the summer to create a body of NHS Supporters strong enough to protect the principles of the NHS for many years to come. The Fed, now in its 21st year of NHS campaigning, believes the need for public involvement could not be greater. Our strategy meeting in March 2010 produced a plan to create the movement of NHS Supporters to help the Fed with its role as a sentinel for the 'protection and promotion' of the NHS. Our online antiprivatisation petition has been a successful first fruit of this initiative.

'An NHS Beyond the Market' The Fed teams up with major partners to organise round table discussion on a non-market alternative NHS

In a joint statement – the outcome of the BMA-hosted Roundtable,on alternatives to the market model for the NHS in England – academics and campaigners from the BMA, NHS Support Federation, NHS Consultants Association, Keep our NHS Public, Unison, Royal College of Physicians and others, produced a report on the alternative to the market based NHS – available on the Fed website - www.nhscampaign

Other Fed highlights:

-revamped the website to involve the public, monthly hits now reached 20,000+

- worked with the NPC to organise a public services march in central London

- continued work with Leigh Day and Unison in legal opposition to health policies threatening the NHS

- profited from our excellent team, of committed volunteers. To; James, Sylvia, Ken, Tony, Kim, Rachel, Ewan, Paul and Campbell many thanks for your help throughout the year.

And last but not least thanks to our ever-supportive founder, the NHSCA.

Contact us at: NHS FED: Community Base, 113 Queens Road, Brighton, BN1 3XG (01273 234822) www.nhscampaign.org /director Paul Evans, paul@nhscampaign.org

KONP REPORT - 28.9.10

The steering group have met monthly at the RMT offices apart from August. We are very grateful for this as accommodation in London is expensive.

- **The White Paper Equity and Excellence: Liberating the NHS** (EEL) These proposals if enacted will destroy the NHS so we are working hard to mobilize public opinion. We have printed 10,000 copies of our response which we believe will lead to privatisation and also have a new edition of the KONP newspaper for sale. Prices on the website. Please disseminate widely. We are going to organise a meeting, in the House of Commons if possible, in November to show the breadth of feeling against these proposals. **'Consultations'.** Although flawed, as they are about the 'how' not the 'what' (according to DH guidance) do respond to the consultations. EEL closes on 5.10.10 as does the analytic strategy and three others about transparency and outcomes, democracy and commissioning close on 11th October. DH website

- **Working with the BMA** We hoped to have another joint meeting after the successful one following the critical report on NHS London's proposals but this did not happen. We have had good links with the London Regional Council and through Council but were disappointed that no mention was made of the impending White Paper at the ARM. Only 3 members of the BMA Council voted to have a Special Representative Meeting (SRM) proposed by one of our members. Any of you who are BMA members please get your division/council to call a meeting asap. We need 30 groups to pass a motion asking the BMA to have a SRM before they will do that. The voice of ordinary doctors needs to be heard and the website response is minute.

- **Website** Paul Lister continues to maintain the website (free) www.keepournhspublic.com for which we are very grateful.

Any comments would be appreciated. We have continued to pay two people to trawl the newspapers to update this, Anna in Scotland and Matt in Manchester.

- **Our submission** to the Health Select Committee was published in March and their report was a devastating critique of commissioning which sadly received less publicity than it deserved. They described it as '20 years of costly failure' and DH officials reluctantly conceded that it cost at least 14% of NHS budget to run the market. WDS attended the new committee meeting where they quizzed Andrew Lansley about the White Paper-he hardly mentioned the private sector, all about clinician control.

- **Alternatives to the Market.** The roundtable conference about this took place on April 14th with Harry Keen, Peter Fisher and John Lipetz representing KONP, NHSCA and the NHS Support Federation. (I was unable to go as I was recovering from a back operation done on 12th)

The report 'An NHS beyond the market' can be downloaded free from the BMA website by anybody. It was released the day before the BMA ARM and again received little publicity. The big conference mentioned last year seems unlikely to happen.

- **Personnel.** Bronwen Handyside resigned in April because of pressure of work and we have employed Adeline O'Keefe since August as campaign manager.She has a campaigning background not in health, but is learning fast. She is doing more hours than Bronwen which is necessary with the White paper threat to the NHS. My secretary Helen Cagnoni has continued one day a week dealing with subs and membership. The database is almost ready to go and we will be able to chase people for subs which trickle in.

- **The AGM on 12th June** was smaller but successful with about 50 members present. John Lipetz cochair gave the KONP report and Bronwen and Candy Udwin talked about campaigning nationally and in Camden. Tom Fitzgerald an NHSCA member has taken over from Dave Eastham as treasurer. Our thanks to Dave for 4 years work were formally recorded. Talks by Dr Richard Taylor MP, the cost of the market, Dr Jonathan Tomlinson GP, personal care, Dr Kevin O'Kane, the liaison between BMA, unions and activists, and WDS the way forward for KONP, were well received. We now have 22 active KONP groups In England and one in Wales.

- **Finance.** We were grateful to get another small grant from the Andrew Wainwright trust and with the grant given by the NHSCA are solvent although with the fight against the White paper will be using more of our reserves. We need £1000 a month for administrative costs and thanks to NHSCA members, SG members and my friends we have managed to get £600 in standing orders. Thanks to all those who are contributing regularly. If you could afford to do a S/O (enclosed in this Newsletter) I will cancel it when KONP ends.

- **Speakers**. Anyone willing to join our speakers list especially outside London please let me know. John Lister & Jacky Davis spoke at the joint KONP London Regional BMA meeting in Feb 'On the Brink'. WDS spoke at the NPC Rally in Trafalgar Square in April and at the Whittington demonstrations twice. John Lister and I spoke at the rally in Huntingdon in July against the privatisation

of the Hinchingbrooke hospital. Colin Leys & John Lipetz have also spoken to various groups.

- **A hustings pack was produced before the election** for prospective candidates and the website and we publicised these through the groups. We sent to all candidates in marginal constituencies along with our booklet 'What kind of NHS do we want?. On the website we displayed the names of those who signed our statement of principles – only Jeremy Corbyn and a dozen green candidates signed which was disappointing.

- **Letters** to the Guardian have been published and do generate interest via the website but rarely cash, even though after a great deal of help from Paul Lister we managed to get the paypal account set up for donations.

- **Our Facebook and Twitter** groups have not grown dramatically but Adeline is adding things more regularly so we will see if they are useful in the next few months. If you feel like contributing please do.

- **Petition with 25,000 signatures** collected over the years saying no further privatisation was delivered to Downing Street in July, by several KONP members, Jeremy Corbyn MP and Dot Gibson (NPC). WDS 28.9.10

CONFERENCE : "THE NHS & THE COALITION" DR RICHARD TAYLOR

Richard, former Independent MP for Wyre Forest, opened by describing the joys attached to being an Independent member for his 9 years before losing his seat primarily through boundary changes "No Whip and just marvellous freedom—".

Giving interesting amusing personal insights into the workings of Health Select Committees, based upon his contributions to the recent Commissioning Report "—- they are expensive, inefficient, fraught with party conflict—ignorance of the NHS is staggering —and the Tories are not interested in Health anyway—", he argued that in his view, the case for yet more major change to NHS management was not justified beyond abolition of the purchaser/provider split –"a 20 year costly failure of an adversarial system with no benefits, absorbing as much as 14% total NHS costs—".

At the same time, he felt that PCTs could and should be strengthened e.g. by deployment of the best of the staff from the to- be-abolished SHAs.

Richard went on to list a range of ways savings and efficiencies could be achieved in the NHS ,whether through better use of resources, better cooperation between disciplines, such as "productive ward initiatives", releasing more time for care of patients, (and yet with only 30% wards in NHS hospitals using this initiative), patients taking on more self-care responsibility for minor ailments, Primary Care services taking on more responsibility from Secondary Care, reduction of incidence of "never events", with wrong site surgery the biggest culprit in terms of numbers. He suggested that it would make economic sense to pay off PFIs NOW and was encouraged by saving which had resulted to the population's health from Parliamentary action allowing a free vote to achieve the ban on smoking in public places. He offered that minimum pricing was the only realistic way of addressing the problem of alcohol abuse and that there were important lessons to be learned on tackling Obesity from his American experience in Atlanta and Colorado.

In advising our Association WHO best to approach in the battles ahead, he highlighted Stephen Dorrell, newly elected Chair of HSC as being publicly sceptical about GP Commissioning, and Earl Howe as being approachable. Overall there could be an improved status for the HSC with a new membership, including Sarah Wollaston(Tory), Andrew George (Lib Dem). He also recommended cross bench peers Baroness Masham, Leslie Turnberg and Baroness Finlay (Wales).

Finally, in answer to questions he advised that lobbying of MPs had limited effect in contrast with Early Day Motions, which can make an impact if , for example, 200MPs were to sign up, this would point to a parliamentary rebellion.

Geoffrey Mitchell

CONFERENCE : "THE SCOTTISH NHS" - MARTIN HILL

Martin Hill has been involved in management in the Scottish NHS for 38 years. This includes a period of time as Chief Executive of a Trust. He disputes the popular belief that the management is top-heavy, but admits that lack of good management and leadership is the real problem.

He expressed surprise that the public in England has so readily acquiesced to the changes which have taken place, and also to those which are proposed. In contrast the Scottish attitude which is much more socially orientated , resulted in a rejection of the Thatcherite policies. With devolution in 1999 ,and the delegation of health policies to the Scottish Parliament , the Labour/Liberal coalition abolished the marketplace in health, and introduced a policy of cooperation between general practice, secondary and tertiary care, and care in the community with the involvement of local councils with the intention of developing the concept of community health partnerships. Trusts were abolished and there was a return to the previous health board structures. There are now 14 mainstream boards, although other health boards administer ambulance services, blood transfusion etc.

The minority Scottish Nationalist party government which has been in post since 2007 has placed no further PFI contracts, and prescription charges are in the process of being abolished.

Direct elections of the public to health boards are being piloted in Fife and the Borders for a five-year period, and it is not possible for commercial organisations to bid for general practices. The picture is very much of the Scottish NHS rather than the NHS in Scotland. There has been considerable consultation and engagement with the public which has made it difficult to close some of the district general hospitals. Waiting times have been considerably shortened and after teething problems, NHS 24 (the equivalent of NHS Direct in England) appears to be working well.

The Scottish Medicine Consortium (equivalent to NICE) reviews new drugs, and the use of generically prescribed medicines is the highest in the UK.

There are no market anomalies as in England where patients may have to travel long distances and there are very few barriers to a cooperative function of the NHS. National (UK) terms and conditions of service apply universally.

Various aspects of the health service are overseen by a national quality assurance scheme, and there is also a national inspection team looking at hospital infections , particularly in relation to MRSA and C.difficile.

The Scottish Intercollegiate Guidelines Network (SIGN) produces guidelines relating to best practice in relation to a wide variety of medical and surgical conditions. These are produced after a wide consultative process, often involving input from the public and are regularly updated.

Overall the Scottish NHS provides a good service, although there is always the danger that some of its functions might be preserved in aspic.

Robert Cumming

CONFERENCE : THE PAUL NOONE MEMORIAL LECTURE
COMPETITION OR COLLABORATION; PRIVATIZATION OF WHAT? MR PETER HAYES

Peter Hayes is now retired but was a financial adviser for Barclays Bank for 17 years before becoming Chairman of the Macclesfield Health Authority and later Chairman of the East Cheshire NHS Trust. His background in both finance and health service management made him an excellent choice to deliver a talk on privatization. Fortunately for the audience, his presentation was full of amusing anecdotes, and yet managed to deliver a serious message at the same time.

He started by saying that he agreed with the principles of the NHSCA that the internal market system was both unnecessary and detrimental. He had come to health service management from the cut-throat world of high finance, but found the world of "markets" in the NHS just as distasteful as the one he'd left behind. Deals were done behind managers' backs, lawyers submitted inflated bills and consultant staff worked in private practice for direct competitors. A lot of time and money was wasted competing with larger, better-financed Trusts, with no obvious benefits in terms of patient care. He was very disappointed that New Labour had not only failed to abolish the unnecessary bureaucracy of the market system, but instead expanded and extended it.

As far as the Coalition government was concerned, he was even more disappointed in the White Paper, which he felt would lead to privatization by stealth. The government claim that there was no hidden agenda to privatize the NHS was quite clearly false – by opening the doors to organizations whose primary purpose was to buy and sell healthcare, they were doing exactly that. The central principle of GP commissioning had numerous problems, not least of which was that GPs would be forced into consortia, and from there it was but a short step to the development of profit-making polyclinics.

He went on to say that the increased patient choice envisaged by the White Paper was a fallacy – in fact the opposite was probably true. GPs within a consortium would be bound to a long term contract with a particular provider, to whom they would be forced to refer patients. The binding together of primary and secondary care units in long term contracts was but a short step away from the "integrated care" that exists in American-style Health Maintenance Organisations. The White Paper would lead to a return to GP fundholding of the 1990s, he claimed, with Darzi polyclinics superimposed. Cost savings envisaged from disbanding of PCTs were also a fallacy. The jobs currently done by PCT staff would still have to be done, so in order to carry out their functions, consortia would have to re-employ staff made redundant when PCTs closed.

In the last part of the talk, Mr Hayes gave his Utopian view of what he thought the NHS ought to look like in the future. He said that the purchaser-provider split should go and that there should be greater co-operation between the various arms of the NHS in order to create (or better still re-create) an integrated non profit-making service. This would be aided by abolition of the artificial division between primary and secondary care and dissolution of PCTs and SHAs, as long as their function was assumed elsewhere. The-target driven culture of the NHS should also be abolished and the commissioning of hugely expensive external audits should be stopped.

Trust Boards should be made up of local consultants, local GPs, members of the public and representatives of local Universities and Deaneries, with reduced managerial representation. Outsourcing of ancillary staff to profit-making companies should cease and relevant staff should be brought back into the NHS, not only to save money but also to increase their sense of belonging and loyalty. GPs should be given back real choice about where their patients could be referred, instead of the illusion of choice currently offered by "Choose and Book".

The huge purchasing power of the NHS should be used to drive down costs. The medicines budget was the second largest expense in the NHS – it seemed obvious, therefore, that the NHS procurement agency should negotiate with pharmaceutical companies to produce the most commonly prescribed drugs specifically for the NHS, possibly under the NHS brand name. A similar tactic could be adopted for other widely-used appliances such as wheelchairs, crutches, walking sticks, even computers. This approach could potentially save a large amount of money that could be freed up for patient services.

Mr Hayes rounded up his highly entertaining talk with a rallying cry to save the NHS, which not surprisingly went down very well with all members of the audience!

Paola Domizio

POLITICAL ACTIVITY

Report on NHSCA meeting with Earl Howe under secretary of state for Quality and government spokesman for Health in the House of Lords. September 1st 2010

In our efforts to influence the thinking of politicians we were fortunate to have the opportunity to meet Earl Howe Conservative Under Secretary of State for Quality in the NHS. Four of us, Robert Elkeles, Peter Fisher ,Deborah Lee, and Geoffrey Mitchell went to Richmond House on Wednesday 1st September. Earl Howe was accompanied by Barbara Hakin, a very senior civil servant who is responsible for implementing the white paper. It would be fair to say that the presence of Barbara Hakin showed that our meeting was taken seriously.

Peter introduced the meeting by explaining the objectives of NHSCA. While we agreed with some of the aims of the white paper we doubted whether the methods proposed to achieve them would produce the desired results. The example of Banbury was pointed out where, following a disputed reconfiguration, services had been successfully redesigned through cooperative planning involving all interested parties. Earl Howe agreed that this was a good model.

Deborah speaking from her experience of paediatrics in Cumbria drew their attention to the importance of different parts of the healthcare providers working together especially in small market towns Here competition had very little place. In some urban areas there were too many small units which need to be merged and questioned how the new arrangements would affect the changes necessary. Earl Howe stated that by using GP commissioning local people would decide on local services. It was unclear how the quality of Commissioning decisions would be monitored except by the NHS Commissioning board. Deborah also asked how the difficult decisions would be tackled. Foundation Trusts worked against collaboration and Networks. Why could the challenging decisions about A&E, Paediatric and Maternity service not be made at a regional level, following the Manchester model of deciding which area needs 24/7 , 8 till late etc. ? Earl Howe responded that the Government wanted local people to make local decisions. He felt that GP commissioning groups should be able to form co-operatives to develop a network approach. How the effectiveness of this process would be monitored was unclear.

It was pointed out that the plan to commission maternity services centrally seemed diametrically opposed to the concept of local decision making. How

would GPs and patients be able to have any input into these decisions? The response was that there would need to be regional outposts of the Commissioning Board.

We then questioned why such a dominant role in commissioning had been given to GPs. Why had government considered that GPs had a monopoly of wisdom in this area. Grave doubts had been expressed about this. We strongly suggested that secondary care specialists should be involved in the commissioning process. Barbara Hakin also replied that good commissioners would almost certainly involve secondary care specialists in commissioning though it was not clear how this would happen or how it would be monitored

We also suggested that that it would be in the interests of the new commissioners together with those of the new private providers to refer as little as possible to local secondary care. This could result in destabilisation of local NHS trusts with possible closure of departments and even of emergency services. We drew on the example of Samantha Cameron having to have her baby in the local hospital while on holiday . It was most fortunate in the circumstance that the local hospital was functioning. We also made the point that replacing 150 PCTs with 500 GP consortia who would all need management expertise to carry out the commissioning would be unlikely to save managerial costs. Peter while supporting the aim to reduce administrative costs by 45% over 4 years, pointed out that these were largely staff pay and the staff were needed to service the complex systems which had been imposed. Attempting to remove layers of bureaucracy without simplifying the structures and processes would be ineffective.

Earl Howe replied that maternity and emergency services such as Accident and Emergency would be somehow ring fenced. However other services and trusts could be closed or absorbed if they were perceived as failing- We all emphasised the need for integrated care rather than the competitive approach though we were not sure this was taken on board.

We also took the opportunity to forcefully describe the adverse effects of the European Working Time Directive on patient care and training of doctors. Earl Howe said that he had spoken at length to John Black, President of the Royal College of Surgeons about this and understood the problems. Other countries were also experiencing difficulties. Moves were afoot to try improve matters. However we were not likely to reverse the European legislation. The new government would try to improve the situation but it was not clear at this stage how this could be achieved.

Our meeting overran its scheduled time by fifteen minutes. Earl Howe said he had found the meeting helpful and constructive. Let us hope we made some impression.

ROBERT ELKELES

Requests have also been put in for meetings with **John Healey**, Shadow Secretary of State for Health and with **Stephen Dorrell,** now chair of the Health Select Committee – responses awaited

Several NHSCA members are involved in a meeting with MPs at the House of Commons on 30th November, organised by KONP.

NHS WHITE PAPER - A GREEN LIGHT TO THE PRIVATE SECTOR

The new Tory government promised no great upheaval or major reorganisation of the NHS and yet the re-organisation of the NHS proclaimed in the White Paper is moving so fast that by the time you read this much may have been superseded by new DH guidance or ministerial pronouncements.

It's not just the upheaval, the waste of money that reorganisation represents and the complete lack of evidence that any of this will work that grates. The rushed White Paper (WP) heralds the biggest change in NHS governance since its creation in 1948. The proposals are complex and far-reaching but not a word of this is to be found in any election manifesto. In my view this amounts to deceiving the public and in its commissioning guise dare I say it, some leading GPs.

Parts of the White Paper are clear and intentional with predictable effects. All NHS hospitals will have to become Foundation Trusts (FTs) which means breaking many of their links with the NHS. Later the intention is to move them further from the NHS as they become Social Enterprises (SEs) 'run by the staff of the hospital'. It is entirely unclear what this means in practice but what is clear is that should a hospital as a Social Enterprise get into financial or performance trouble they will be offered to private companies who will move to 'rescue' - I would say capture – the hospital's services.

This is the clear path to privatisation of NHS hospitals and continues the direction of travel followed to their shame by the Labour Government. Meanwhile all community health services are to become part of FTs or become SEs. So the whole provider side of the NHS will be distanced from the NHS and its ethos and readied for privatisation.

The headline grabbing sting in the tail of this White Paper relates to what is intended for the commissioning side of the NHS - GP Commissioning Consortia (GPCC).

GPCCs are billed as groups of practices which will be allocated 80% of the total NHS budget and will decide on treatment for their populations. They will be Statutory Bodies and have an Accountable Officer. In other words they will resemble the PCTs that are to be abolished. The myriad of duties currently carried out by PCTs under Statute will have to be found new homes; many of these tasks will be given to GPCCs I expect – the legal list of doctors able to practice as GPs, GP appraisal and revalidation, patient complaints, allocation of patients to practices, decisions about practices where the GP retires or failing practices and so on.

So I have a very simple question: If the aim of this government exercise is to increase the 'power' of GPs in the commissioning of NHS services why did the government not simply issue 'guidance' to each PCT to form a GP Commissioning Committee that takes the lead on all commissioning decisions of the PCT and is binding on the PCT?

The answer has in part to be that the government agenda was to achieve more than 'putting GPs in the driving seat'. The answer has to make sense of the abolition of PCTs, the disbursement of their duties. GPCCs represent the 'parcelling up' of a commissioning body distanced as far as possible from the NHS, Should GPs fail in their new role the private sector stands ready to take over the task in a similar way to Health Maintenance Organisations in America.. This would be game, set and match to the privatisation of our NHS.

Are GPs willing and able to take on these responsibilities?

A few probably are both willing and able but the majority of GPs and their practices struggle to keep up with the daily demand of delivering general practices services to their patients. Each GPCC will need a few GPs to head up the clinical side of the commissioning process which will inevitably be run by commissioning managers much as today. The key to any success the GPCCs have will rely on the 'buy in' from constituent practices. Will all GPs abide by the commissioning rules set by the GPCC? How will consensus be achieved or disputes resolved in terms of what not to commission in the face of a shrinking budget? Does a dissatisfied patient complain to their GP about services no longer available when their GP is complicit in local decisions?

A seemingly obscure but now key factor in the involvement of GPs and their practices is the ambiguity of GPs' status within the NHS. GPs are Independent Contractors to the NHS along with dentists, optometrists and community pharmacists. They are self employed yet have a public sector pension and regard themselves as part of the NHS. Up until the late 1990's they had a monopoly of general practice provision within the NHS but Personal Medical Service (PMS) contracts between individual practices and PCTs broke the monopoly allowing professionals other than GPs to hold PMS contracts. With the invention of Alternative Personal Medical Services (APMS) contracts, where any willing organisation can hold general practice contracts the private sector were allowed to tender for vacant and new general practices.

So GPs are in an ambiguous relationship to the NHS and will have an ambiguous position in GPCCs as both commissioners and providers of NHS services. Yet still they are apparently to be handed £80bn of NHS (tax payers') money.

The BMA along with the BMA's GP Committee (GPC) on which I represent The Medical Practitioners' Union section of Unite has decided to adopt 'constructive engagement' with government over implementation of the WP. It's a pragmatic move which I understand since out-right opposition to GP or other clinical involvement in the commissioning process would not make sense.

This has led to many on the GPC saying that their involvement in GPCCs is to save the NHS from the potential ravages of the private sector. They understand they may fail but at least they want to give it a go!

Again to an extent this is understandable because just as other doctors have witnessed and been on the receiving end of poor management in the NHS – often reacting to the latest 'must do' from the DH – so have GPs. GPs do have a continuing relation with patients and do daily hear of the bureaucratic and often irrational culture of the NHS; the unhelpful primary/secondary divide; the long-winded patient pathways. So they feel they could organise things better than PCT managers negotiating with hospital and community services managers. No doubt hospital doctors feel they could manage aspects of general practice better than GPs. The answer of course is for clinicians from general practice and hospitals to sit down together to amend, re-vitalise or design better patient pathways.

Readers with good memories (circa. 1999) we used to have Primary Care Groups (PCGs) which included nurses, GPs, local authority, public health, PAMs and often hospital and community consultants. These were invented to put 'doctors and nurses in the driving seat' (again) and were beginning to rationalise local care and patient pathways just before they were disbanded and PCTs invented. PCTs had to have Professional Executive Committees with a membership that included (forgive me for being repetitive) nurses, GPs, local authority, public health, PAMs and often hospital and community consultants.

The new PCT configuration did not evidently 'solve' poor commissioning so the Labour Government invented the 'World Class Commissioning' programme. PECs were effectively replaced by a few GPs explicitly appointed and employed by PCTs. Then came the election and the invention of GPCCs.

So GPCCs are in one sense part of an evolutionary process of involving clinicians (mainly GPs) in the commissioning process – fundholding, GP Commissioning Groups, Primary Care Groups, PCTs and now GPCCs.

And there has been the another evolutionary process – the privatisation of NHS provision : tendering for cleaning, catering and laundry, concordats with the private hospitals to 'increase NHS capacity', Independent Treatment Centres, private companies buying 'vacant' GP practices, PFI and finally that phrase 'any willing provider' the final insult to the ethos of the NHS. If this evolutionary process has been the 'creeping' privatisation of NHS provision, we are about to enter massive privatisation of NHS provision.

GPCCs represent explicit clinician involvement in the commissioning process and can be supported. But the government by abolishing PCTs has given the green light to the private sector to run the GPCCs all be it headed by a few GPs.

The following comment from the University of Liverpool's Department of Health Inequalities and Social Determinants of Health sums up my concern:

"The White Paper's proposals are ideological with little evidential foundation. They represent a decisive step towards privatisation that risks undermining the fundamental equity and efficiency objectives of the NHS. Rather than "liberating the NHS", these proposals seem to be an exercise in liberating the NHS's £100 billion budget to commercial enterprises"

(Whitehead, Hanratty, Popay) Lancet 2010

RON SINGER

Retired GP and President, Medical Practitioners' Union (Unite)

CONSOLIDATION OF LABORATORY SERVICES
WHAT THE CLINICIAN NEEDS TO KNOW

Laboratory services are ripe for privatisation. In the 1980s & 1990s a few individual laboratories were privatised (e.g. Lister hospital, Stevenage, West Middlesex hospital) but these services have been handed back to the NHS. Although they have not been exposed as failures, it can be assumed that neither delivered the benefits anticipated by the hospital nor by the private provider. What the independent sector would prefer is acquisition of a swathe of laboratories- and this is what the government has set out to provide.

In September 2005 Lord Carter of Coles was appointed chairman of an independent review of laboratory services. He was asked to benchmark current services in England against international standards. In particular he was asked to comment on benefits arising from "wide scale service reconfiguration, innovation and modernisation and involvement of the independent sector". Government expectations were clear. Some 200 bodies and organisations including the Royal colleges of Pathologists and Physicians submitted evidence to Lord Carter The "Report of the Review of NHS Pathology Services in England" commonly known as "The Carter Report" was published in august 2006 - but with a few crossed wires. Health Minister Lord Warner in his press release stressed the need for greater networking of services, for exploring the lessons to be learned from the independent sector in providing routine tests, and said he expected substantial efficiency gains of at least 10%. This was rather at odds with Lord Carters Report which suggested setting up pilot projects to examine models for commissioning and organising Pathology Services, and to collect data on true costs without which he was unable to assess the extent to which efficiency could be improved. He warned against fragmentation of services which could follow involvement of the private sector. It was not quite what the government expected which probably accounted for the timing of its release in august.

The Carter Report showed that the expenditure per capita on in-vitro diagnostics in England was about half that of equivalent countries in Europe and a quarter of the expenditure in the USA. Lord Carter was unequivocal in his praise for the quality and commitment of pathology staff and for the service provided. The problems he identified were ones over which pathology departments have little or no control - the phlebotomy services, specimen transport and IT systems .These issues are likely to require solutions tailored to local need and it is difficult to see how a network which is centrally managed could respond appropriately. There were further contradictions within the Report. Lord Carter advocated recognition of pathology as a core clinical service integrated with patient pathways, but at the same time recommended the creation of "stand -alone pathology service providers" which would have the characteristics, but not the statutory rights of an independent Trust. Some pathologists might welcome the gain in autonomy and control but most favour maintaining close links with their host Trust.

In support of Lord Carters comments on the excellence of the service was the Healthcare Commission (HCC) Review "Getting Results" published six months later in March 2007. The HCC compared services in 2003 and

2005 and found faster turnaround times, a wider range of tests, better control of demand, longer opening hours and a substantial increase in productivity despite the "slow development of pathology networks". Only 8% of Trusts had responded to the government directive and belonged to a formal managed network. The HCC found that pathology services were generally held in high esteem by hospital clinicians, particularly with regard to the quality of the guidance and interpretation provided. Not surprisingly, there was no press release drawing attention to this review whose findings beg the question "What are we trying to fix?"

The second and final report of this review undertaken by Lord Carter of Coles was made public in December 2008. There is much that is good in this report with its emphasis on quality. However an explicit recommendation is made for "consolidation" of pathology services which will radically change the management and configuration of pathology services in England and which may clash with these quality standards. Consolidation goes beyond collaboration. It will require the establishment of one or more centralised core laboratories in each SHA This super-lab, and the hot labs on each hospital site will have a single clinical manager and a commercial manager. Savings of between 250 and 500 million a year are expected but these computations are imprecise. It is also a concern that the risks associated with consolidation and its impact on clinical services was not assessed in the Report. The proposal is clearly aimed at facilitating a take- over by the independent sector. Establishing a pathology tariff has been a priority and Collinson Grant Healthcare undertook a costing exercise around the 12 pilot sites. Establishing a tariff proved costly and difficult. Although realistic funding for pathology is to be welcomed, the move away from a population based tariff to a fee for service re-imbursement is ominous. It facilitates privatisation by reducing private sector risk. It also hinders our role as advocates for the patient in terms of establishing evidence based practice, instituting demand management, and providing a service as opposed to merely performing tests.

Management changes are not just matters of debate for pathologists. Clinicians should take steps to ensure that clinical services are not adversely affected. The following issues should be considered when changes to your pathology service are proposed. Firstly, it should not be assumed that savings generated by consolidation and centralisation through economies of scale, will be substantially greater than the true costs of maintaining and running such a service.

SAVINGS

Savings will be identified as (current cost/test – new cost/test) x projected test numbers. The projected test numbers will be hugely inflated (see demand management below) and these may be just one off savings.

COST CENTRES

Laboratory premises: Will the new build super-lab be privately owned or a PFI? If the former, managers will be engaged in attracting new business and the venture may fold if they do not succeed in doing so. If a PFI, the cost burden will be considerable.

Laboratory Equipment: Rapid advances in laboratory technology require frequent upgrading of expensive equipment. Several mechanisms exist for the introduction of new technology – reagent rental, lease purchase, operating leases, managed service contracts etc. The duration of the lease and the term of contract are crucially important. Long term contracts are more economical but less flexible

IT Systems: There has been no integrated pathology IT planning. Robust IT connectivity will require considerable expense and expertise. The advantages of centralised testing will be negated unless results are easily and rapidly available and easily accessible with links enabling all users to share information.

Transport: Responsible for the greatest delay in specimen processing and the weakest link. Rigorous new legislation applies to specimen transport on the highways so is expensive and most likely to suffer cutbacks and staffing problems. Appropriate collection schedules must be established at the start and continuously audited. Flexibility is required in response to clinical demand especially during epidemics and outbreaks.

Travel: Managers, laboratory personnel, and consultants will need to travel between sites and to the central laboratory. Apart from the direct cost of travel, this is unproductive time which will require restitution. Will your Trust have to increase consultant numbers to make up for this loss of time?

Local "Hot Labs": The loss of economies of scale will mean that the hospital laboratory will become more expensive to run. Overall, Trusts are likely to see a considerable rise in the cost of laboratory services. If adverse weather conditions delay transport and IT communications malfunction Trusts may be compelled to perform more tests on site further increasing laboratory costs.

Environmental Costs: It is reasonable to demand an evaluation of the environmental impact of the increase in transport and travel. There will be an apparent reduction in laboratory equipment, but they will be running for longer periods of time as they will be dealing with the same number of tests.

There are other considerations.

Demand Management: Economies of scale are just that: the greater the number of tests performed, the lower the cost per test. The low cost of screening will invite abuse. Excessive and indiscriminate use of screening profiles is undesirable and may lead to what has been termed the "Ulysses syndrome". A healthy patient with a false positive test may be sent on a frustrating, stressful and quite unnecessary journey in search of a diagnosis and requiring further investigation. Demand management is not only clinically desirable but is also a means of reducing total pathology costs. It should be noted that with the introduction of a tariff, the profit margin will increase as the cost per test falls -so it is unlikely that a private provider will be enthusiastic about demand management.

New tests are likely to be foisted on users before optimal evaluation. Withdrawal of tests found to be less than useful will meet with resistance especially within a long term contract.

Quality and Audit: The reduction of laboratory costs is misplaced as a prime aspiration. There are several instances where introduction of a new, more accurate or more rapid but costly test has had the effect of reducing

the total cost of patient care. The quality and clinical relevance of the service would be a more fitting core objective. This will require close collaboration between clinicians and pathologists. Only investigations "requiring a rapid turnaround on clinical grounds "will be processed on site. Who will decide which specimens will be deemed non-urgent and what is the clinical impact of delay if a specimen is transported to a central laboratory?

The quality and accuracy of test results are a prime concern for pathologists and any misgivings they may have with regard to the service provider must be taken seriously.

The quality of a test result is only as good as the quality of the specimen but this is often overlooked. The quality of the specimen must be maintained during storage and transport. It is particularly true in relation to microbiology. Transport media will, to some extent, ameliorate the effects of delay on microbiological specimens. Some specimens e.g. CSF have no such safeguards. What is the acceptable time delay between collection and examination of a CSF specimen? See below.1

All aspects of the service must be monitored by robust integral audit programmes

Transfer of risk: Requires clarification but details of transfer of risk arrangements are usually shrouded in secrecy. Commercial confidentiality is usually cited as a reason for withholding information. Risks relating to aspects of the service such as transport and IT must be separately identified as they may well be outsourced.

The first super-lab: Guys and St Thomas' Hospitals in a joint venture with Serco established GSTS Pathology incorporating a super-lab. At a first year assessment, the Trust Board "expressed concern over quality and clinical governance issues, and data security risks". Other concerns were the "poor engagement of clinicians" and the "pressure on management engaged in winning additional business."There was also "concern as to whether the transformation programme had delivered the expected benefits to the Trust". Questions of whether there should be an independent review of the contract were also raised.

Despite these negative observations, exposed in Private Eye but not widely reported, plans for consolidation are likely to affect your pathology services in the near future.

1All textbooks searched state that CSF specimens must be examined "as soon as possible". Any delay may affect the result as cells lyse at variable rates on standing particularly affecting specimens with low cell counts e.g. TB and Listeria.

THE ROYAL MEDICAL BENEVOLENT FUND

The Royal Medical Benevolent Fund (RMBF) is an independent charity that provides medical practitioners, and their dependents, with practical support at times of difficulty or crisis. The RMBF is the largest of the UK medical charities, and provides support for doctors from across the profession. In 2008/9, the Fund helped 12 doctors remain in work, 17 to return to practice; 47 medical students received assistance and 12 doctors were funded to study or return to work.

Making a difference

The assistance that the RMBF provides supplements statutory provision, and may include financial assistance to enable retraining, assist with other costs, or alleviate hardship, in the case of those unable to work. The RMBF has made a difference to the lives of large numbers of doctors and their families, enabling many to turn their lives around.

In the past, the RMBF was often regarded, inaccurately, as a charity for the widows and orphans of doctors. The introduction of the NHS pension scheme represented a landmark, as it guaranteed most NHS doctors financial security in retirement. Demographic trends have also changed the profile of those in need. The RMBF has responded to these changing demands. The Fund assists an increasing number of younger practitioners, asylum-seeker and refugee doctors and doctors with health problems.

In recent years, the RMBF has undertaken larger projects, aimed at identifying issues affecting the wider profession, whilst continuing to support individuals. The RMBF has commissioned research into "doctors in difficulty" and into strategies to support single-handed general practitioners. The RMBF has funded a debt counsellor to work with the Physicians' Health Programme, a London-based initiative providing services for doctors with health problems. The Fund has also established Money4MedStudents, a website, providing medical students with advice on personal finance.

Consultants can help the RMBF in a number of ways

The RMBF relies on contributions from members of the medical profession to continue to help those in hardship. Most doctors will be familiar with the Annual Appeal. Doctors can make individual donations or they can join the RMBF and make an annual donation. Legacies are also a significant revenue stream, and doctors can easily add a codicil to an existing will.

In clinical practice, we may encounter colleagues in hardship, often due to illness or disability. Many beneficiaries were unaware of the Funds' existence, until their doctor suggested contacting the RMBF. Consultants, particularly those with pastoral responsibilities, may become aware of "doctors in difficulty" locally. Simply spreading the word, to raise awareness, helps. The Fund deserves a higher profile.

There are many opportunities to volunteer as RMBF officers. Consultants are particularly suited to these posts. The Area Visitor role involves meeting beneficiaries, and their families, to establish how best the RMBF can assist. This may involve signposting beneficiaries to other agencies, providing personal support or arranging a package of interventions. At times of crisis, doctors appreciate sharing worries and concerns with a non-judgemental and sympathetic colleague. Area Visitors work closely with the RMBF case work team. For several years, I have seen, at first hand, how the Fund has made a real difference, helping a number of doctors return to clinical practice. I have been moved and touched, to see doctors regain their dignity and self-respect, as they return to work.

The Medical Liaison Officer role involves promoting awareness of the RMBF and other services for colleagues in difficulty. Senior doctors have a network of contacts with GPs and consultants, locally and regionally, together with medical directors, responsible officers, clinical tutors and deans. Medical managers regard Liaison Officers as a valuable resource and a source of wise advice. Liaison Officers are always in great demand to give talks at departmental meetings, grand rounds, LMC meetings and "training the trainer" events. Liaison Officers act as "the eyes and ears of the Fund", identifying new issues facing the profession, and suggesting how best to respond.

Local Event Organisers are also required to organise fund-raising events. Organisers work with the guilds-local volunteers-to host social events, for example dinners or balls, or sporting events, such as inter-hospital cricket matches. These are all flexible commitments that are particularly popular with retired doctors, although quite compatible with full-time practice.

The future

Changes in domestic UK health policy will have a dramatic effect on doctors and their careers. Today, doctors graduate with significant debt. Tuition fees for medical courses will rise and graduates will remain in debt for many years. Oversupply has resulted in a growing number of fully-trained general practitioners and specialists, who cannot find substantive posts. Medical unemployment is now a reality, and likely to increase, as market forces replace workforce planning. In a commercialised healthcare system, uncertain portfolio careers will replace "jobs for life". A shift towards outsourcing and subcontracting will lead to less favourable terms and conditions, short-term contracts and more sessional work, with fewer employment rights, such as statutory sick pay. Illness, personal crisis or the inability to work will have devastating consequences. Doctors working for corporate providers will lose the security of the NHS pension scheme. These trends will present new challenges. The RMBF will continue to work to find new ways to meet the needs of doctors in hardship.

Thomas Fitzgerald

Consultant Anaesthetist, London

SPECIAL MEETING OF THE BMA LONDON REGIONAL COUNCIL - 4TH NOVEMBER

There is probably an office somewhere in Whitehall dedicated to producing stirring and meaningless titles for government policy documents. What, asked a speaker at last week's London Regional Council meeting at the BMA was "Equity and Excellence - Liberating the NHS" liberating it from? Rationality he suggested.

The meeting looked at the impact of the white paper proposals across the medical profession. Short presentations from representatives of different craft groups were followed by a lively discussion.

The strength of the BMA lies in its nationwide coverage of all strands of the profession through both the regional and craft group structures and it was extremely informative to have the perspectives of so many different groups within the profession. This same breadth of representation however is a weakness when it comes to providing a coherent and unified response to the white paper. While most speakers were opposed to the white paper they all had different issues with it.

Media attention has, understandably, concentrated on the proposals for General Practice consortia and Foundation Trust hospitals and their commercialisation, so it is easy to overlook what is not in the White Paper.

Prof David Katz pointed out that there is a "gaping hole in the middle" of the White Paper in that there is no mention of academic medicine or undergraduate education. He felt that introducing the purchaser provider split in education would undermine the educational process and said there was no evidence that it provided value for money or increased diversity.

Tom Dolphin, chair of the junior doctors committee, was much less concerned by the growth of markets in health care, focussing instead on the lack of coordinated responsibility for post-graduate training. He described the White Paper approach as "vague and incoherent".

He deplored the proposals for Health Education England to cover all health care professionals, stressing their different needs, and described the idea of local workforce planning as "a disaster"

Staff grade doctors are another group to which the White Paper makes no reference although there are now some 20,000 of them in the NHS. Their representative too was concerned by the prospect of local responsibility for training and conditions of service which he felt would lead to a loss of mobility for these doctors.

Eloquent presentations on the dangers of fragmentation and privatisation and the disastrous likely impact of the White Paper proposals on the hospital service were provided by Jacky Davis and Anna Athow.

Predictably perhaps the GP view was somewhat different. David Wrigley, a GP from a currently successful commissioning group in Lancaster was happy with the purchaser provider split and only against enforced competition of providers. He felt that his group were developing successful integrated and cost-effective care working with their local hospital and should be free to develop this.

One of the few voices in favour of the White Paper proposals came from someone describing himself – perhaps significantly – as the "Managing Director of a General Practice" rather than as a GP, who insisted that it was no longer a question of whether but how the white paper would be implemented; the bill had been written, it would obviously be passed and GPs "had to make it work."

Public Health has also remained outside the White Paper proposals but, the meeting was told, is facing its own major upheaval – arguably as radical and to a shorter time scale than the rest of the NHS. All directors of public health are to be transferred to local authority control with effect from next April although the terms of employment have still not been agreed and the public health white paper has not yet been published. The consultant speaker said that the specialty was potentially the "last bastion of independence" but were likely to be too stretched to contribute to commissioning and planning.

A wide range of views were expressed by the audience. Many believed that the BMA should take a strong line and even that doctors should take to the streets. A motion was passed calling for the BMA to hold a special representative meeting and members were urged to get their local divisions to call for this.

It was widely agreed that the public were "in denial" and that the government are winning the PR battle with convincing slogans. It was agreed that the profession needs to explain the issues better to the general public.

There was however also a strong streak of fatalism if not helplessness. We had got to "move on" it was suggested, GPs were already starting to "work out how to make it work" and the BMA "could not be seen to derail the process".

In fact here seems to be the most extraordinary momentum to the whole process. It was said that "no-one thinks it is a good idea" with reservations having been publicly voiced from such unlikely sources as the NHS Confederation, the Financial Times, the Kings Fund and even the Treasury. Four out of five doctors are reported as believing it would harm patients. Yet the government is oblivious to the concerns. Even the opposition of the Labour party seems to be in doubt.

To me the meeting demonstrated the strength of feeling against the white paper within the profession but also the extent of government success in splitting the profession and in inducing the belief that the juggernaut cannot be stopped.

JANET PORTER

RESHAPING THE NHS AND THE IMPLICATIONS FOR CONSULTANTS

This comprehensive report, by Stewart Player with Colin Leys, was referred to in the Editorial.

It has already been distributed electronically to all members for whom we have email addresses.

Some of the comments received:-

- *Thank you very much – most useful!*
- *As Hon Sec of the Association of British Neurologists (ABN) as well as a firm supporter of the NHS, this is of huge concern. It is a really well written report, thank you.*

We would like all our members to have a copy and will send it electronically on request.
Hard copies are also available, if preferred, at a cost of £3 to cover printing and postage.

Dismantling the NHS

Behind the technicalities, what do the Con-Dems' plans for the NHS really mean? **STEWART PLAYER** and **COLIN LEYS** expose the reality of the health service White Paper

The coalition government's plans for the NHS represent the final conversion of health care into something to be bought, with really good care going to those who can pay for it and only a defined 'package' of free treatments, of declining quality, for everyone else.

What has already occurred with dentistry,physiotherapy, podiatry and other services will start happening across the board. 'Top-ups' and 'co-payments' will become standard. More and more conditions will be defined as ineligible for NHS care, while some treatments will cease to be available freely on the NHS and have to be paid for - if you can afford it.

It's already happening all over England, as staff and services are cut to meet the government's demand for £20 billion 'savings' over the next five years. GPs are being told to refer many fewer patients to specialists. Haringey, in north London, has announced a moratorium on hip and knee replacements. The government's plans mean that this will become the norm, not just one-off cuts justified as a response to a crisis.

Under the new plans, by 2014 NHS hospitals will no longer be answerable to the taxpayers who have paid for them over the years, and will no longer have the overriding aim of providing the best possible health care for the their local community.

By then they will all be businesses, competing with private hospitals and clinics for NHS patient income. To stay afloat financially they will have to cut costs, reduce staff, lower the 'skill mix', reduce levels of pay, focus on profitable treatments and neglect or even abandon high-cost and unrewarding ones in order to match the for-profit sector. There will also be many fewer of them.

The aim is to take chronic care out of hospitals and deal with it in non-hospital settings - 'super-surgeries' or clinics, largely owned and run by private companies. **It will be a healthcare market, very like that in the US.**

All hospitals, public and private, will be answerable only to a central regulator, Monitor, which is concerned only to ensure that they stay solvent and behave competitively.

They will be supervised for safety and quality by the Care Quality Commission, but the CQC is notoriously feeble: it gave mid-Staffordshire top marks while several hundred patients were dying there from neglect.

The White Paper says the CQC will become more demanding. But if in future it tells a hospital to raise its standards, and the finance director replies that the required improvements are unaffordable, what is supposed to happen? There will be no bailouts. The government's view is that the hospital should either cut some services, or even close altogether, leaving patients to be treated by better, privately-owned hospitals - or perhaps in the same hospital, after it has been taken over by a private company. That is the logic of the healthcare market the White Paper envisages.

But closing a medical department or even a whole hospital isn't like closing a department in a department store, or the store as a whole. There are rarely adequate alternative facilities within reach. Letting hospitals fail means chaos, anxiety and serious risks for patients and their families.

And what if the private company's services turn out to be no better? The quality record of the privately-owned Independent Sector Treatment Centres (ISTCs), set up and subsidised at huge public expense by Alan Milburn during his time as health minister to treat NHS-funded patients, is notoriously worse than that of NHS hospitals doing similar work.

Whether it is health care or home care or schools, good public services for all must come in the end from a service ethic on the part of staff who are not in it for the money, and management who are not in it for shareholders (or forced to compete with companies that are run for shareholders). Outside regulation has a part to play, but without the core commitment that comes from being part of a national service that expresses the solidarity of society - in the case of health, the solidarity of all the well with all the sick - equally good services for everyone will soon be a thing of the past.

Commissioning

The proposed change that has attracted most attention is the shift of commissioning from Primary Care Trusts (PCTs) to 'local consortia of GP practices'. This is being done on the grounds that 'primary care professionals' are best placed to know what is best for patients, and will engage in 'more effective dialogue and partnership with hospital specialists'. Who could object to that?

You do wonder why PCTs haven't previously been told to organise such a dialogue between GPs and specialists; but the more important point is that GPs can't in fact do commissioning.

What the Con-Dems' plans mean for the NHS

- The Tories' NHS white paper will create a market in healthcare a lot like the one that exists in the US. It is the culmination of a decade-long campaign by the private health industry to get its hands on the NHS budget.
- By 2014 hospitals will be independent businesses, competing with private hospitals and clinics for NHS funding.
- Hospitals that 'fail' will be left to go bankrupt and close. There will be no 'bailouts'.
- GP 'consortia' will run the service, in theory. But doctors don't have the time or skills to do the large amount of administration required - and these are the contracts the private health companies are after.
- There will be £20 billion of cuts. On top of that, the more complex the market system gets, the more money will be spent on administration instead of medical care.
- The consortia will end up trying to reduce costs by denying certain treatments. And if they are to make money, they will have to do it by employing fewer, cheaper staff.
- What remains of the NHS will be run for profit. But it will, essentially, be dismantled.

'Commissioning' is Department of Health-speak for purchasing, and what it means in practice is setting the terms of what exactly will be paid for: what services will be covered, how they will be delivered, by clinicians with what sorts of qualifications, following what protocols, with what limits on length of stay in hospital, prescribing what drugs and rehabilitation programmes, and so on. These so-called 'care pathways' are at the heart of commissioning or buying health care. The payments are per-patient, at pre-agreed prices for each kind of treatment package.

And to ensure that the deal pays off, any variation from the agreed protocols must be cleared with the commissioner or purchaser. This is the meaning of the 'managed care' operated by America's notorious HMOs (health maintenance organisations), in which doctors have to plead with the HMO to be allowed to go ahead with a needed treatment that the HMO says is unnecessary, in reality because it will cost more than the HMO wants to pay.

Viewers of Michael Moore's film Sicko will remember a doctor who used to work for an HMO telling a congressional committee how she was paid a bonus according to how often she denied treatments to patients. The new 'GP consortia' may not go so far as to reward their staff on this basis. But they will have limited budgets, and the way they are supposed to reduce costs is precisely to involve themselves in the details of all the treatments they are going to pay for. Someone will have the job of denying something.

Two big deceptions

1 Who will really run the new GP consortia?

Some GPs are said to be keen to take on commissioning. But the work involved is essentially commercial, not medical. The new consortia will have to employ large teams of administrators, lawyers and others to negotiate, make contracts, monitor performance, send out bills, do audits, deal with disputes, and so on - as PCTs are already doing.

That is the first big deception involved in this change. It sounds as if GPs will be doing the work, when in fact the essential job of buying hospital and other services involves a vast range of tasks that practising GPs can't possibly do, and aren't trained to do, even if they stopped treating patients altogether. In fact, the work calls for skills developed in the managed care industry in the US. The English health care market is going to be run on the principles developed there, not by GPs whose 'pivotal and trusted role' is supposed to be central to it.

The change will also mean that GPs will be nominally responsible for the £20 billion of service cuts that are already starting to be made. How trusted they will still be after that remains to be seen.

2 The cost of commissioning

The second big deception is that focusing on who does the commissioning prevents a crucial question from being asked: that is, why do commissioning at all?

Running health services as a market is far more costly than running them as a public service. The Department of Health commissioned a study of the NHS's administrative costs. Based on 2003 data, the authors found that administration absorbed about 14 per cent of the total budget, up from 5 per cent in the 1970s before the marketisation process began.

The department sat on the report for five years. It only came to light in 2010, by which time 'payment by results' (payment for every individual completed hospital 'episode') and other major additional market elements had also been introduced. The share of administrative costs is probably now 18 per cent or more.

The ideologues behind the Tory plan maintain that competition makes healthcare providers more efficient. But the evidence from the US suggests the opposite.

There is a good reason why this is so. Good health care is above all a matter of enough, highly-trained staff; yet employing fewer, cheaper staff is the only way to make money out of it.

In reality, the plan to turn the National Health Service into a healthcare market does not rest on rational arguments but material interests. Any realistic strategy to resist the Tory

plans must start out from that fact: the plans are not really new, but are the culmination of a decade-long campaign by the private health industry to get its hands on the NHS budget.
How otherwise could the white paper have been produced so fast - a mere two months after a general election during which none of its far-reaching proposals was even mentioned (let alone made an electoral commitment) by either of the two parties now in office? It's hard to imagine that even the overall shape, let alone the detail, of the white paper, was put together in two months. So where did it come from?

The HMO/market model: how its foundations were laid

The reality is that successive Labour health secretaries, working closely with the private sector, had already constructed almost the entire edifice of a healthcare market. The Tory plan merely speeds up the final stage and makes it more clearly visible.
The idea that New Labour planned to replace the NHS with a US-style market, complete with HMOs, may come as a shock to some readers. But the fact is that HMOs have been the inspiration behind practically every element of the 'system reforms' pursued by New Labour since 2000.
One HMO in particular, California-based Kaiser Permanente, the largest HMO in the US, has been intimately involved in shaping the Department of Health's strategic thinking. New Labour's 'reforms' have been worked out in constant discussions with and visits to Kaiser. This includes the conversion of NHS trusts into independent businesses (foundation trusts); the introduction of ISTCs; payment by results; giving NHS work to private hospitals and clinics and encouraging NHS patients to choose them; changes in NHS staff contracts; and, not least, the development of HMO-style commissioning.

Who's taking over the NHS?

The main actors in the new GP consortia

The earlier attempt to encourage GPs to take on commissioning roles through 'practice-based commissioning' has been widely acknowledged to be a failure, mainly because most doctors prefer to focus on patients. This allows the 14 major US and UK health corporations, consultancy firms and insurers that currently make up the 'Framework for Procuring External Support for Commissioning' (FESC) to step in and play an increasingly central role in allocating the bulk of NHS finances. The FESC functions include population risk assessment, procurement and performance management, and data harvesting - but it is in service redesign that their impact will be most felt.

So who are these companies?

Aetna (US); Axa PPP (UK); BUPA (UK); CHKS (UK); Dr Foster (UK); Health DialogServices Corporation (US); Humana (US); KPMG LLP (US); McKesson (US); McKinsey (US); Navigant Consulting (US);Tribal (UK); UnitedHealth Europe (US); and WG Consulting (UK).

The US example

These changes have been introduced in a largely piecemeal fashion, concealing their overall intent. But when looked at with reference to the Kaiser model the various elements assume their true significance.
A defining feature of the US healthcare market and its HMOs is its complexity, with myriad forms of organisation and bureaucracy fragmenting provision, and with thousands of different 'plans' (i.e. insured packages of care) confusing customers, concealing profits and adding hugely to costs. It was precisely to avoid this expensive dog's dinner that the NHS was created. But the basic structure is clear enough.
An HMO like Kaiser receives insurance premium income from its 'enrollees' (and for over-65s, from the US state's Medicare programme), and then 'manages care' for them through three basic 'arms':

1) It owns hospitals and primary care/ambulatory facilities; which are 2) staffed by physicians, who, while nominally independent, are tied into an exclusive relationship with 3) the company's insurance arm.

How do the New Labour/Con-Dem plans correspond to the US model?

At the level of infrastructure, hospitals are being progressively removed from public ownership (all NHS trusts are to become foundation trusts and are then to become 'social enterprises' owned by their staff, not the taxpayer), while privately-owned facilities are subsidised (sweetheart deals for ISTCs, charitable status given to Nuffield hospitals, etc).
Some struggling NHS hospitals will close, while others, such as Hinchingbrooke in Cambridgeshire, will be handed over to private companies to be run for profit. Mark Britnell, who was the Department of Health's head of commissioning under New Labour and is now lucratively installed in the private sector, says Hinchingbrooke is 'only the tip of the iceberg' and anticipates perhaps 20-30 more such transfers over the next year.
ISTCs, too, provide ready-made privately-owned venues for ambulatory and short-term secondary care, while some 150 private hospitals and clinics in the 'Extended Choice Network' that are already available to NHS patients under the 'choice' agenda form the nucleus of an expanded network of private suppliers.
In terms of staffing, the Kaiser model calls for market relationships with independent teams of consultants, primary care physicians and nurses. In order to develop these, staff must be disengaged from the NHS and redeployed into the above-mentioned teams.
The main initial lever to bring this about will be the significant numbers of hospital doctors who become redundant under the cuts programme. At the same time, GPs already have a semi-independent status and can more readily be included in such teams, which have already been emerging in parts of the country. While such teams may initially have some autonomy, it is unlikely that they will be able to compete with the major providers in the long term; it is more likely that most will end up working for one or other of them, on the Kaiser model.
The third arm of the HMO model, the insurance function, will be the work of the new commissioning consortia, advised by - or, more likely, progressively outsourcing the work to - private health insurance companies, and some American HMOs. There are also indications in the white paper that patient choice of GP will in due course extend to choice of commissioning consortium - since all GPs will be required to belong to one, so free choice of GP means free

How these companies profit from the 'revolving doors' in senior health personnel

- **At KPMG**, the former Department of Health head of commissioning Mark Britnell now leads the company's European Health Division. Britnell also has close ties with Dr Foster, having previously been one of its non-executive directors..

- **UnitedHealth** now employs Blair's former top health adviser Simon Stevens. It also has the former head of the Department of Health's commercial rirectorate, Channing Wheeler, who, alongside Britnell, set up the FESC before being recalled to the US to face the securities and exchange commission on charges of illegally backdating share options at the time of 9/11.

- **BUPA** has the services of former health secretary Patricia Hewitt in her role as advisor to the private equity company Cinven, which recently bought out BUPA's entire hospital portfolio.

- **Tribal**'s director of its healthcare division, Matthew Swindells, was chief information officer of the Department of Health and a special adviser to Patricia Hewitt. The company can also call upon Phyllis Shelton, who jumped ship from the Department of Health, where she worked as the lead for measurement on the integrated care organisation programme. Prior to this, she was the founder and managing director of the UK arm of HealthDialogue.

- **McKLesson**'s UK chairman is Lord Carter. As chairman of the NHS's competition panel, he is well situated to ensure that decisions on mergers and procurement - including those on commissioning - will follow the privatisation route.

- **McKinsey** has the Department of Health's former head of strategy, Penny Dash. Some idea of Dash's influence on the commissioning front can be seen in the fact that, in her guise as vice-chair of King's Fund, she led a recent briefing for PCTs to cut back on commissioning of what she considered to be 'low-value' medical procedures. Sure enough, in June this year, NHS North London proposed cutting back on 'low priority treatments'.

choice of commissioner -and that the consortia and hospitals will become free to compete on price and not just on 'quality' as they do now. It is likely that competing healthcare 'plans' will eventually be a feature of the market here too, as consortia begin to compete for patient income.

The insiders

Pushing through these changes is a tight-knit 'policy community', comprising a number of leading private sector figures, some doctors and some health policy think-tanks, working closely with a group of strategists within the Department of Health. Among the latter a highly influential figure has been Professor Chris Ham, who was for some years head of the Department of Health's strategy unit and is now director of the King's Fund. Ham has been a long-term champion of Kaiser, organising a series of visits to the company's California headquarters and being instrumental in setting up a number of 'Kaiser beacon' projects within the NHS to introduce and 'normalise' Kaiser's aims and methods among NHS managers.

Even more emblematic is Dr Penny Dash. After working briefly for Kaiser in the 1990s, Dash was appointed head of strategy and planning in the Department of Health, and co-authored the NHS Plan of 2000, which initiated the marketisation process. Since then she has served on the board of Monitor, led Lord Darzi's recent review of health services in London, and is currently vice chair of the King's Fund.

But it is Dash's function as placewoman for the global consultancy giant, McKinsey, that is probably most significant. McKinsey has been described as the gold standard for the provision of corporate strategy advice to the Fortune 500 companies, and as 'global thought leaders' in the areas of strategy and operations management. The company has played a central role in 'system reform' in the NHS under New Labour and Dash is now a partner in their London office.

One of her initiatives, the Cambridge Health Network, is essentially a McKinsey front for exchanges between private health corporations, financial institutions and the Department of Health. Sponsors of the Network include some very big game: Halliburton, General Electric, and Perot Systems, as well as our very own GlaxoSmithKline, BUPA, Assura (now owned by Virgin), Mott McDonald and Carillion. McKinsey has been in many ways a key architect of the reforms that have prepared the way for the Con-Dems. It was also, not coincidentally, McKinsey who came up with the figure of £20 billion that is now starting to be cut from the NHS.

Resisting the destruction of the NHS

As everyone recognises, successful resistance to the Tories' plans permanently to cut back public services will call for a mass mobilisation with exceptional levels of solidarity, organisation and commitment. But as Gregor Gall has recently pointed out, the defeat of the poll tax - the last time anything on this scale was successfully attempted - is not a good analogy with the situation we face now.

The poll tax affected everyone; its injustice was massive and obvious; and it required people to co-operate by registering and paying the tax, which they could and did refuse to do in vast numbers. None of these conditions apply to the complex, uneven, protracted process of dismantling the NHS that the Tories intend to push through. Yet the injustice that will flow from the loss of the NHS will be massive. It will change the face of English society more profoundly than the poll tax. And it will be for all practicable purposes irreversible. Unless we stop it now, all of us resisting in whatever way we can.

Dear Editor,

I was impressed by a detailed, intelligent, informative and alarming programme on Radio 4 recently on nursing homes and the Care Quality Commission (File on 4: Tuesday November 23).

I think NHSCA needs to move away from attempting to engage with politicians, with the BMA and with various NHS support groups, towards more engagement with the public – Women's Hour, Today, Panorama, File on 4, You and Yours etc – there are so many untapped stages.

One way would be to write to the directors of these programmes with our views, expressed as bullet points, to entice them with a potential programme – for which we would contribute suitably verbally cognate and well-informed speakers from NHSCA (not necessarily just the EC).

Our introductory letter should point out that most programmes deal with problems, tragedies and disgraces that have already happened, whereas we are offering the public a chance to learn about and engage in something that is about to happen but which they can prevent – more akin to climate change than Mid Staffs.

I wonder whether we have, amongst our membership, an amateur film director who could be invited (with support) to produce a series of fictional vignettes illustrating each of the bullet points – a conversation with a GP about a referral directed by contract rather than choice, a hospital closure, an expensive patient refused etc – and offer this in our submissions to TV programme directors.

We must act soon!

Patrick Zentler-Munro

Any help from members regarding media contacts, filming etc would be gratefully received. Ed

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