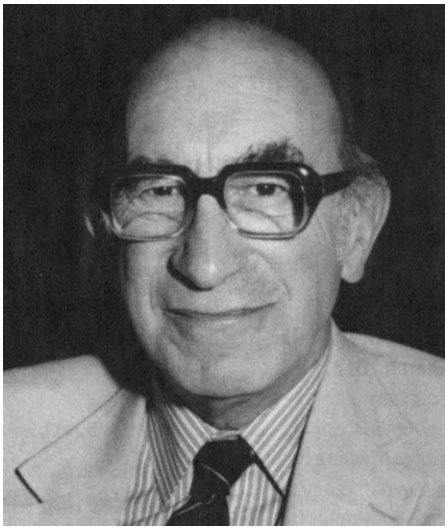
NHSCA

June 2013

Harry Keen (1925-2013)



Most NHSCA members will probably remember Harry Keen primarily as a campaigner for the NHS, as we are reminded by Paul Evans' accompanying memoir. Probably his most celebrated action, mentioned by Paul, was his attempt to challenge in the high court the secretary of state's power to act in advance of parliamentary approval of legislation, something which incurred potential financial risk for Harry. Here I will concentrate on his professional career.

Harry was born in London in 1925 and studied medicine at St Mary's Hospital. He qualified in 1948 a few weeks before the inauguration of the NHS. These were the days before pre-registration jobs and his first experience of clinical medicine was as a locum general practitioner, doing his visits on a bicycle. Later he worked in the department of medicine at St Mary's under Professor George Pickering, whose principal research interest was hypertension and who engaged in a famous dialogue/dispute with Robert Platt about its nature and causes. Pickering was a major influence on Harry and introduced him to a second major influence, RD Lawrence at King's College Hospital, where Harry worked for several years as a research assistant in the Diabetic Department (where, incidentally, I first met him). At that time there was much competition in specialist and academic medicine; it was the era of the time-expired senior registrar. In academic medicine it was widely regarded as a necessity to acquire the BTA (Been To America) and Harry duly went to the National Institutes of Health, Bethesda, to work with James B Field, whom he had met when Jim Field spent some time in the Diabetic Department at King's. Here he learned the techniques of measuring insulin action using preparations of the rat diaphragm and the rat epididymal fat pad. He also did some exploratory work on isolating islets of Langerhans from rat pancreata following the tying of the pancreatic duct, borrowing from Frederick Banting's experiments prior to the isolation of insulin.

After returning to the UK, Harry obtained a lectureship in the Department of Medicine at Guy's Hospital under Professor John Butterfield, whose principal clinical and research interest was diabetes mellitus. Clive Sharp, then Medical Officer of Health for Bedford, was interested in screening for disease and approached John Butterfield for help in a diabetes screening programme in Bedford. John Butterfield engaged Harry and Roy Acheson (Reader in Social Medicine at Guy's) in the planning of

something more than a simple screening exercise – more of an epidemiological study. At that time the criteria for diagnosing type 2 diabetes using blood glucose levels were many and varied and were all quite arbitrary. Several experts were consulted and were asked what levels of blood glucose they would regard as completely normal and what levels they would regard as definitely diabetic. It was decided to identify people in this grey zone (called 'borderline diabetes') and follow them prospectively. Subsequently, Harry was invited by Geoffrey Rose to participate in the Whitehall Study (now Whitehall 1), which was more orientated to cardiovascular disease, but which included a diabetes element similar to that in the Bedford Study. The two studies came to broadly the same conclusions and helped rationalise the diabetes diagnostic glucose levels. They also showed that levels of glycaemia below those diagnostic of diabetes were associated with increased risk of coronary and cerebral vascular disease.

Inspired by the simplified immunoassay for insulin devised by Nicholas Hales and Philip Randle Harry, with Costis Chlouverakis, devised a similar assay for urinary albumin. This was applied in a cross sectional study by Ron Hill. Follow up of these patients showed that in both type 1 and type 2 patients, even moderately raised levels of urinary albumin predicted increased morbidity and mortality, later found to be true of non-diabetics also.

People with type 1 diabetes traditionally need to inject themselves with insulin one or more times per day. In the early 1970s Harry learned that John Parsons had used subcutaneous infusions of parathyroid hormone for patients with hypoparathyroidism and thought that this might be a potential means of delivering insulin. Together with John Pickup he set up a research programme to investigate this. The result, CSII (continuous subcutaneous insulin infusion, usually called the insulin pump), now with sophisticated technology, has become a widely-used treatment for people with type 1 diabetes.

Harry was also greatly concerned with treatment, both in terms of therapy and of organisation, of diabetic patients. He was a pioneer in the employment of specialist nurse practitioners in the education and management of individual patients and groups. He persuaded management to fund a 'metabolic ward' at Guy's, with four inpatient beds, available for various metabolic investigations, but principally for clinical, teaching and investigational procedures relating to the diabetes service. He was involved in many national and international bodies concerned with diabetes, not least the British Diabetic Association (now Diabetes UK). At Guy's he headed the directorate of clinical services for medicine when the administration was reformed. He also played a prominent role in several notable clinical trials.

Harry was unusual in encompassing laboratory skills, epidemiology, clinical medicine and administration, and he endowed each with extraordinary enthusiasm and energy. He will be missed by many.

John Jarrett

EDITORIAL

A look back to the future

David Levy

As guest editor of this edition, I planned it with a Mid-Staffs theme. Three months after the long-delayed publication of the report seemed the right distance to lend some decent perspective to the latest in a series of crisis interventions after catastrophes in the NHS since Ely Hospital back in the 1960s. To date, with a few exceptions, the response (including the government's) to Robert Francis' herculean efforts has been muted and shockingly uncritical, apart from the expected headline-grabbers (nurses to do bedside nursing as part of their training, an unresolved question about minimum nurse staffing levels, and heads that should have – but didn't, and were never really going to – roll). An organisation like the NHSCA with clear views on the aberrant

direction of travel in the NHS and a membership of extraordinary depth of national real-life experience should be generating thoughtful and balanced views to contribute to the debate. We hope you will find a quartet of them in this issue. But the discussion must continue, and we'd like to hear other members' thoughts as the enormously complex outcomes pick their hazardous way through the financial and political minefields.

It's poignantly appropriate that at a crisis-induced crossroads of development of the NHS we should also mark the passing of Harry Keen. His life was a magisterial marker of the high politics and the very best of clinical academic medicine in the NHS since 1948. Although we will all remember him for his lifelong and unwavering support of the NHS founding principles, his medical career and his extraordinary contribution to the science of diabetes and its epidemiology marks an equally important pinnacle of the NHS ideals of academic brilliance in the service of our patients. The metabolic team at Guy's under Harry's leadership produced breathtaking research over decades at the very highest levels. We won't see a personality like him again, and I suspect in the new NHS research environment we won't ever see a body of clinically meaningful research like his either.

HSMRs and Francis – their role in Mid-Staffs and their future in the NHS

Brian Jarman

Introduction

Hospital Standardised Mortality Rates (HSMRs) were developed in the early 1990s, originally when our unit at Imperial College was given the job of calculating the resource allocation formula for England. The idea was to see if some hospitals had particular problems that might require additional funding. It was evident that adjusted mortality was the only measure that could be used reliably in this way and also for monitoring purposes (concisely described as 'bombproof and actionable' by the medical director of a US hospital). Death is a definite event that has to be registered by law, and unlike morbidity, it does not have the problem of knowing if the condition was present on admission.

Although people may not like to think about death rates, they do understand them and knowing the numbers could be important for patients and their relatives. At the Bristol Inquiry into death rates in paediatric cardiac surgery units, parents of the children who died could have been told that the adjusted death rate for open heart surgery in children under one year at Bristol was 29%, but they only need to have driven about an hour up the motorway to find a unit with a third of that rate. Adjusted death rates are important for patients and relatives and are factors that could be considered in any reorganisation of paediatric cardiac surgery units, but the complexity of their interpretation means that more than a decade on from Bristol, controversy still surrounds the future of other paediatric cardiac units such as Leeds.

HSMR and their meaning

Hospital death rates vary with age, sex, diagnosis and other factors and the HSMR is defined as the ratio of the number of observed deaths in a hospital over, say, a year to the number expected if the hospital had the national death rate for each age, sex, diagnosis group, etc for which adjustment is made. We usually emphasise

the diagnostic groups that have the largest number of deaths and the published HSMR covers 80% of all hospital deaths nationally (but they are also calculated for all hospital deaths). Previously we used the 10th revision of the International Classification of Diseases, but now use the ICD-10 grouped into 259 Clinical Classification Groups (CCGs), developed by the Agency for Healthcare Research and Quality in Bethesda, USA. Clinicians seem to find these useful. The top 56 CCG groups therefore cover 80% of all hospital deaths in England. Each year the national HSMR is standardised to 100.

Within the HSMR it is not possible to give an exact figure for the number of unnecessary or excess deaths but one can derive a figure that represents the difference between the actual observed deaths and the expected deaths and give 95% or 99.8% confidence intervals for this figure. It would be impossible statistically to calculate the precise number of deaths that were unnecessary, or to pinpoint which particular incidents were avoidable; that requires a detailed case note review. The data only indicates, and can only indicate, the number of deaths that occurred (the observed deaths) and are above (or below) that which would be expected of a hospital with the case mix that a hospital presents. A high HSMR should serve as a trigger to ask searching questions and ensure that any underlying clinical problems have been effectively dealt with.

HSMRs, publicity and Mid-Staffs Foundation Trust application

From 2001 onwards HSMRs were published annually in national newspapers; Mid-Staffs had had a significantly high value for about 10 years. The value published in April 2007 was 127, that is 27% above the value that would have been expected had the trusts had the national death rate adjusted for the factors I have previously mentioned. The Department of Health advised readers of the newspaper: 'We would strongly advise against patients using these figures to make decisions about the relative safety of hospitals.' The April 2007 HSMR came at an awkward time for Mid-Staffs in relation to its application for Foundation Trust status. In March 2007 the West Midlands SHA approved Mid-Staffs to apply for FT status but the Application Committee of the DH was not told of the high HSMR when considering the Mid-Staffs application. It was therefore passed to Monitor which gave its approval in December 2007; Monitor had been told that the Mid-Staffs HSMR was 101 (which it had been, but only for a single month during that year). There was also no mention of a 2007 Royal College of Surgeons report of an invited review that described the surgical division as dysfunctional.

Further warnings

The Mid-Staffs report described the trust's culture as 'one of self-promotion rather than critical analysis and openness. This can be seen from the way the trust approached its FT application, its approach to HSMRs and its inaccurate self declaration of its own performance. It took false assurance from good news, and yet tolerated or sought to explain away bad news.'

In April 2007 our unit at Imperial College started sending monthly mortality alerts to the chief executives of any acute trust in England that, on at least one occasion in the preceding three months, had had a risk-adjusted mortality of double the expected rate for particular diagnoses and procedures. We copy the alerts to the Healthcare Commission (now the Care Quality Commission). Between July and November 2007, while Mid-Staffs was making its FT application, we sent the Chief Executive four mortality alerts. Patients also expressed concerns about the quality of care at Mid-Staffs but Nigel Ellis, head of investigations at the Healthcare Commission, said in paragraph 96 of his statement to the Mid-Staffs Inquiry: 'The concerns from local patients obviously added significantly to our level of concern about the trust but it is important to clarify that these concerns were raised with us after the mortality alerts had caused HCC to contact the trust. These letters, important though they were, were not the initial prompt for the investigation.'

HSMRs and mortality alerts contributed to the saga of Mid-Staffs, and may be one of the factors that are taken into account in the new quality agenda, together with patient and staff surveys. In February, in response to a request from the Prime Minister, Sir Bruce Keogh (Medical Director of NHS England, previously and briefly the NHS Commissioning Board) announced an investigation into hospital trusts that are persistent outliers on mortality indicators, five on the Summary Hospital-level Mortality Indicator (SHMI), and nine that have been outliers for two years on the HSMR. That raised the question as to what organisation Sir Bruce could ask to investigate those trusts. Until the Mid-Staffs inquiry, the CQC considered that its primary responsibility was to regulate against its 16 essential standards and to correct care that was not compliant. Its job was not to investigate possible individual instances of clinical failure or clinical quality. So Sir Bruce's dilemma was that the organisation responsible for checking all hospitals in England to ensure they are meeting national standards was not responsible for investigating possible individual instances of clinical failure or clinical quality.
We are told now that NHS England has draft proposals to assess CCGs using (published) quarterly traffic light ratings and five 'domains' (quality of care; NHS constitution patient rights; performance, including waiting times; outcomes; finance; and any conditions on their registration) and that NHS England will intervene to replace the leaders of seriously failing CCGs.

Whatever happens, it is still difficult for clinicians to draw attention to patient safety issues without fearing dismissal. Another continuing problem is that only a very small proportion of patient complaints that are not resolved locally are ever fully considered. For example, in 2011/12 the Parliamentary and Health Service Ombudsman for England formally investigated only 222 of patients' complaints raised against NHS hospital, specialist and teaching trusts – a minuscule proportion of the 83,233 written complaints about hospital services in that year alone.

The CQC's 16 essential standards.

The previous 24 Core Standards have been replaced with 16 key requirements that providers must apply and against which they are assessed.

They are:

- Care and welfare of service users
- Assessing and monitoring the quality of service provision
- Safeguarding service users from abuse
- Cleanliness and infection control
- Management of medicines
- Meeting nutritional needs
- Safety and suitability of premises
- Safety and suitability of equipment
- Respecting and involving service users
- Consent to care and treatment
- Complaints
- Records
- Requirement relating to workers
- Staffing
- Supporting workers
- Cooperating with other providers

The Francis report a huge opportunity missed?

Heather Wood

Introduction

There was probably never a halcyon period to work as a clinician in the NHS or to be a patient in it, but it certainly seems far from paradise now. We have had a series of scandals involving poor patient care, the most recent being Mid-Staffs NHS Foundation Trust. I led the original investigation at the Trust, conducted by the Healthcare Commission, which exposed the lack of governance and a Board which put finance and becoming a Foundation Trust above the care of patients.

Almost everything that could be wrong in the diagnosis, care and treatment of patients admitted on the emergency care pathway was wrong. And the roots of that lay in the culture and priorities of a Trust that had lost its way.

The publication of the Healthcare Commission report in March 2009 triggered calls for a full public inquiry. The original Inquiry by Robert Francis published in 2010 fell short of this but exposed even more comprehensively the extent of poor care. Cure the NHS, a group of patients and relatives who had experienced some of the worst that Mid Staffs had to offer kept up the pressure for a full public inquiry and later in 2010 the incoming Conservative government agreed. This second inquiry was not to focus on the care itself but the failure of regulators and the NHS hierarchy to detect and remedy it.

Mid-Staffs as an NHS 'norm'?

For many of us this seemed an unparalleled opportunity for a forensic diagnosis and exposure of the underlying problems that beset the NHS. Despite denials from ministers and the Department of Health, many if not most NHS staff knew the issues at Mid-Staffs were not unique. It might have been an extreme case, but there were plenty of other hospitals towards that end, and many with at least pockets of comparably dreadful care. Although there had been earlier scandals involving individual practitioners or services, it now appears that low standards of care are endemic on many general inpatient wards. In many places doctors dread the prospect of having elderly relatives (or even themselves) admitted to their local hospital or indeed almost any hospital for anything other than a routine minor procedure. So the hope was that Francis would reveal the fundamental pathology at work in our much loved health service.

Managerial rise as another norm

What demanded exposure above all was the relentless political interference in priorities and inexorable rise of general management in the NHS over the last 20 years. This has been accompanied by the decline of power and influence of clinical staff and with it overall standards of care. Only in specialist units is the balance still generally with clinicians and standards more likely to be maintained.

The NHS has been taken over by professional managers who are unregulated, have no binding code of conduct or ethics, and in the end, follow the bidding of their masters, whether or not it is in the interests of patients. And frequently it isn't. A lack of courage and conscience in NHS managers lies at the root of many care disasters in our hospitals, and in a more market-driven NHS, corporate reputation trumps openness to an even greater extent, and is prioritised over the safety of patients. Developments and improvements in the NHS are almost entirely due to innovations produced by medical and scientific research, implemented by clinical and technical staff, not management. The age-old problems in the NHS that should be within the realm of managers to resolve (inefficient administration, wasteful bureaucracy) seem more intractable than ever.

NHS senior managers have over the last 20 years prioritised achieving Foundation Trust status, finance and various targets over safe

and compassionate care, particularly in A&E, assessment units and general wards, often against the advice of clinicians. Ministers and mandarins have tried to argue both are achievable, but this has turned out to be a myth in many acute hospitals. Scandals at Stoke Mandeville and Maidstone and Tunbridge Wells showed that the pursuit of financial and waiting time targets directly affected the focus on infection control, concerned doctors and nurses were pilloried, patients were not adequately isolated and cleaning was not sufficiently thorough. In turn this led to serious outbreaks of C.*difficile* with corresponding patient deaths.

Did Francis succeed?

Did Francis directly expose the pathology of overweening management? No, he did not.

His report lacks focus; the wood cannot be seen for the trees. Of course much of what he says is right and important, for example ensuring the medical regulatory bodies permit student and junior doctor training only in hospitals with acceptable standards of medical care. But there are far too many recommendations. These give the Government and the NHS hierarchy room to hide, and scope for kicking the report and its recommendations into the long grass, where it will join the collection of other worthy works that have not brought sustained material change. The fact that the Government has announced the return of a ratings system shows that nothing has been learnt from the underlying messages in the report. The management hierarchy will announce various untested initiatives, those peddling leadership courses and management consultancies will make money, and in hospitals and on the wards nothing will change.

Francis committed a serious error in missing or at least evading the core underlying pathology. He ordered hundreds of tests, described even more symptoms, but then sidestepped the elephant in the room by resorting to the safe but meaningless diagnosis of 'whole system failure'. Everyone is to blame, no-one is to blame. He has allowed ministers and mandarins to evade accountability, despite everyone intuitively knowing that the tone, priorities and workings of the system came from the top, not frontline staff. Indeed one could argue that a 'whole system failure' indicates that the whole system is run by the wrong people.

Arctic winds of change

In his letter to the Secretary of State Francis refers to 'a culture focused on doing the system's business – not that of the patients.' Many consider that establishing that culture by brute (psychological) force and threats to careers is the trademark of the top tier of NHS management. The management at Mid-Staffs behaved as they did because that was how they were expected to behave; their priorities reflected those of their masters.

Francis denied there was evidence of bullying at or by the Department of Health. It seems he did not look too hard. The Health Services Journal published a survey late last year in which it was clear that many Trust Chief Executives felt bullied. Among others, David Hands presented direct evidence of some of the tactics at the inquiry (BMJ 17 April 2013), and Gary Walker exposed the same methods used to discredit those raising concerns in his recent evidence to the Health Select Committee.

There were significant changes between the closing submission made by Tom Kark and the lengthy but ultimately watered down final report. For example Kark described Sir David Nicholson's claim that Mid-Staffs was a 'one-off' as 'dangerous'. In the published report, Francis notes merely it would be unsafe to assume it has not or will not be repeated.

As Hands notes, Francis admits that his recommendations were influenced by those he criticised. It seems that his findings were also affected by the response, and quite possibly the lawyers, of those individuals and organisations. I recognise that pressure, I've felt it when writing investigation reports including Mid Staffs itself. I would have thought Francis was better able to withstand it. He talks of a culture of fear, and it is possible even he felt its icy blast.

Amongst all the detail and recommendations, the key elements get lost. And because Francis refused to be, or was not allowed to be, in the so called

'blame game', nobody has been held accountable: 'to focus on blame,' he said, 'will perpetuate the cycle of defensiveness, concealment, lessons not being identified and further harm'. But in the absence of accountability, that cycle has simply been reinforced.

Ultimate unaccountability

It is impossible to imagine another area of civilian life involving such poor care and so many unnecessary deaths where there would be no accountability at a senior level. The message to NHS managers is clear: 'Carry on as before; obey your masters' orders and you are untouchable'. Conversely, as many know to their cost, blow the whistle and say goodbye to your career. The reward for the team at the CQC that exposed Mid-Staffs was to be scrapped. For doctors and nurses, probably the only groups with at least the moral authority to challenge dubious and unsafe edicts from the NHS hierarchy and their own managers, the record on valuing dissent is not good. Did we need to spend so much time effort and money to tell us that a closed, secretive culture is not in the interests of patients, and then not diagnose its roots? Although Francis made recommendations on whistle-blowing and gagging, through leaving the entire upper echelons of NHS management in place, few have any confidence anything has changed. Which is exactly how those with vested interests in holding the reins of power want it.

Francis let successive governments and mandarins off the hook by not exposing the damaging effect of political and managerial interference in the operation of health services. He exposed the workings of the acute NHS and its regulators in superb detail but missed the key part played by ministers, the unassailable dominance of managers and subsequent degrading of professional ethics and care. He sidestepped nailing responsibility for the creation and maintenance of a system that protects itself at the expense of patients. For nobody to be held accountable is a very poor message to send out. It might be said to be inexcusable after three years, £13 million of public money, nearly 1800 pages, and 290 recommendations.

Francis, culture change and the consultant: a plea for local priorities

Geoffrey Mitchell

No culture can live if it attempts to be exclusive
Mahatma Ghandi

My contribution to the debate on this important report is narrowly focussed upon the hospital scene as it affects the consultant and the impact upon the patient and carer. It is heavily influenced by my own clinical experience...

In the process of becoming an NHS consultant and pursuing an enjoyable career in adult psychiatry, both in teaching and non-teaching hospital settings, I experienced a wide variety of ways my mentors and colleagues conducted the time –honoured ritual of the ward round.

I suspect that the various patterns of Scottish and English psychiatry I encountered between the mid- 1960's and mid-1990's were more varied and idiosyncratic than in the general medicine and surgery specialities of the day. Even so, perhaps like me they had a significant impact upon your own style of practice.

As Senior Registrar, I worked with one intense consultant and his team which focused on psychoneurosis and minor personality disorders. Most of the day was taken up with staff and community meetings and individual psychotherapy sessions, with emergency consultant- led meetings that could arise at any time of day or night, with the expectation that all team members, including consultant, and patients, of course, should attend.

My next immediate attachment was to a formidable Orcadian lady, nationally recognised as the Scottish doyen of organic psychiatry. She

never forgave me, on returning from leave, for having turned her traditional bedside teaching ward-round into a team-centred conference away from the bedside and involving disciplines previously never involved in ward rounds – social workers, psychologists, OTs, patients, and sometimes relatives. "Oh! Geoffrey, what have you done to my ward? You even have social workers taking part – and in a side room!"

Local professional innovation

Returning as a consultant to the north of England where I had grown up, I soon realised that the asylum, the threat of which was regularly used against my brother and me, was truly a place to avoid, even as a consultant, with its more than 2000 patients mostly neglected unvisited elderly organics and odd, long- forgotten cases of schizophrenia – and not much rehabilitation. This now distant world of the 1970s nevertheless had its positives for a young consultant. There was wide scope to develop clinical services to one's personal pattern, with management prepared to dip into the coffers, and close working relationships could be established with community social work teams with minimum fuss and bureaucracy. Soon we had a functioning community team- orientated model and patients once again on the move.

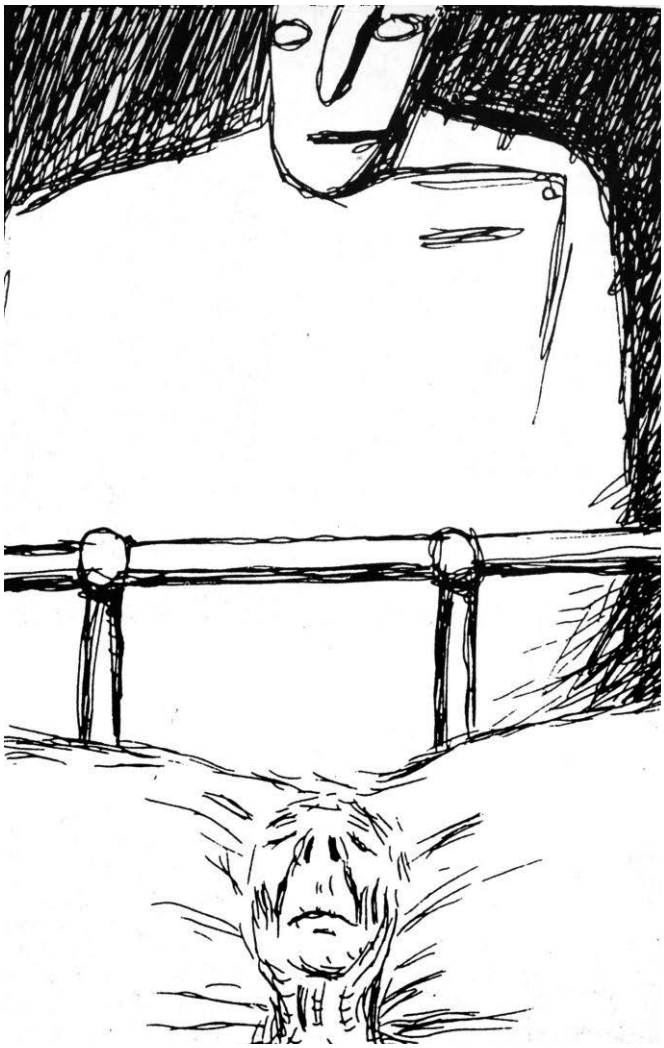
Francis, the RCN and RCP – a potentially powerful trio

Returning to my title, why am I interested in what Francis has to say about consultants, culture change, and leadership and ward rounds? I am in agreement with him and the RCP and RCN that change is needed, on which the last two focussed a joint report, called 'Ward rounds in medicine. Principles for best practice' and the RCP's 'Hospitals on the edge? The time for action' which Robert Elkeles discussed in the last newsletter.

However, both reports concern me, in particular because although they are well-written with systematic analysis of the pressures facing acute hospitals and consultants, they fail to look imaginatively at possible compromise solutions. Francis seems to have been influenced by both reports and not fully briefed on the culture change consultants need. Francis made much in his report of the need for nurses to show care and compassion as expressions of their contribution to culture change but what about the consultant?

Thankfully we have moved on from the worlds of Edinburgh's old-style psychiatrist, her London counterpart Sir Lancelot Spratt, and their grand ward rounds serving as the stage for an act of flamboyant self- importance, with all other players, including the patient acting out a deferential and subservient role.

But with current hospital consultants under daily pressure to find beds, with inadequate time and nursing staff to conduct ward rounds, and continuity of patient care (particularly in the elderly with multiple co-morbidities) compromised by EWTD and the associated poverty of trainee support, it is time to ask urgently: where has it all gone wrong and more importantly how is it going to be put right?



Continuity and integrated care

Continuity of care is emphasised as the greatest concern in the RCP Report 'Hospitals on the Edge' with the negative impact of within-hospital moves on elderly patients rightly highlighted. Yet the mechanics of creating better links with primary care and what this means for the patient is barely touched upon, beyond a throw-away paragraph among the 10 priorities listed, blandly stating: 'We must ensure the availability of primary care services whenever they are needed, including at the weekend and at night.' How can this be delivered in the modern five-day world of general practice and a hospital world traditionally slow to develop links with social services?

Most of the 'priority areas' are vague in stating how change is going to be achieved, whether it be in promoting dignity and patient-centred care, redesigning services, changing the way we organise hospital care, reviewing medical education and training, ensuring the right mix of medical skills, revolutionising the way we use information, embedding quality improvement across the system, and showing national leadership. If many of these are 'aspirational' (Robert Elkeles) then what is the time scale? It would be reassuring to hear that the other Royal Colleges are working together to find solutions to some of these fundamental issues.

The ward round as a cultural centrepiece

Turning to the joint RCP/RCN Report 'Ward rounds in medicine', the same short-sightedness is evident in the summary of an otherwise well –reasoned report of why the ward round is central to daily clinical activity. Understandably in a joint medical/nursing report, the role of the nurse as being at the hub of patient care is emphasised in the daily bedside clinical review, but only passing reference is made to the importance of extending the review to beyond the bedside and to involvement of the patient and other professionals in his care.

If, as this report suggests, protection of time and resources for ward round activity is a necessary duty of managers and Executive Boards, then surely the case has to be made by clinical argument, even to the extent of persuading adoption of a 'spend to save' approach which incorporates new ways of thinking, such as emergency screening, psychiatric liason and staff training programme for the elderly, 48 hour wards with daily ward MDT involvement of primary care colleagues, and patients and carers complementing the traditional bed-side review. Such innovations are happening in my local acute hospital and the potential impact on bed availability and quality of patient management is substantial.

No, I have not forgotten Francis, nor altogether dismissed his recommendations, even though I feel that he has missed the point of what culture change and the consultant is all about. He has usefully summarised key themes fundamental to good clinical practice and good communication which apply not just to the elderly although they are contained in Chapter 25 entitled 'Common Culture applied: the care of the elderly.' But again he displays little awareness of what cultural change is required for consultants in the setting of a rapidly expanding, expensive, increasingly specialised and pressurised NHS or awareness of how and why other team members, apart from nurses, should be involved, in bridging the gap between the patient, his carers, and primary care support essential for continuity.

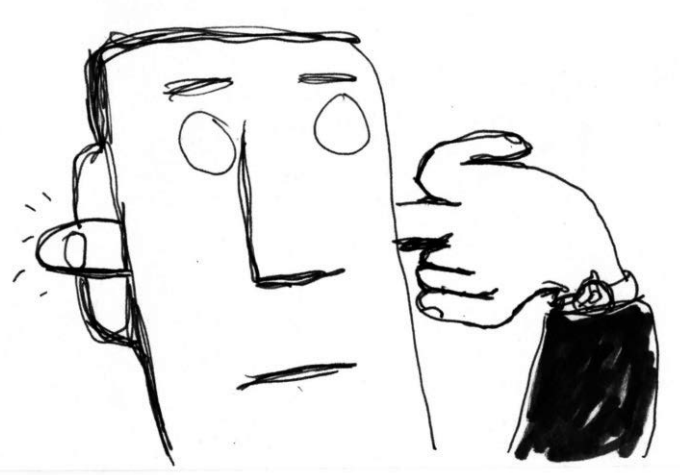
I am only too aware that preaching to a consultant body from a position of retirement and the privileged freedom offered to my generation of psychiatrists to develop services carries its dangers, but I speak increasingly frequently as a patient and as a patient's representative through my Healthwatch connection – and all is not well.

Conclusion

Hospital consultants need to embrace "cultural change" positively, authoritatively and realistically before it is too late. Recent initiatives taken by the RCP highlighting changing priorities and the pressures to provide a coordinated

service should be welcomed and debated and solutions agreed and presented to Trust Boards as proposals which are to be implemented. Acute Hospitals are providing increasingly specialised services and in the process are in danger of squeezing out emergency medicine (and recruitment to the speciality) and the generalist in the face of day-to-day pressures to find space for patients who are frail and elderly with complex medical and social problems, and for whom there is no immediate safe refuge except inappropriate admission as an emergency. The traditional grand teaching consultant-orientated ward round has had its day: in its place there needs to be a better model than the one emerging, one which is focussed on the multi-faceted needs of the patient, bringing together colleagues from other disciplines, who have a contribution to make towards continuity of care beyond the hospital and importantly, towards prevention of inappropriate readmission.

Is it too much to hope that the newly created CCGs may also have an impact on the future shape and priority developments in the acute general hospital, by defining for example, that there is a need for more generalists to provide care for populations for which they are responsible as purchasers and that there is a need to move towards a 24/7 provision by all the vital support services?



The Francis report, 'a case study in failure': lessons almost certainly not learned

David Levy

The lessons

- Organisational or geographic isolation
- Inadequate leadership
- System and process failure
- Poor communication
- Disempowerment of staff and patients

In 2003, Kieran Walshe analysed major NHS inquiries between 1969 (Ely Hospital, Cardiff) and 2001 (Bristol and the beginning of the Shipman inquiry), and accurately predicted the conclusions of the Francis report 10 years on. Walshe suggests that the recurrence of these almost identical themes is persuasive evidence that we do not learn lessons. The explanation that a triple mantra has delivered these successive failures – new public management, neoliberalism, and neoconservative public policy – is at least as plausible as the prevalent view, which is that all we need is more of the same, but with increased rigour and more safeguards. This, in the main, is what Francis has delivered. This is not to imply that he is not a deeply serious public servant repeatedly emotionally taken aback at the individual stories that were presented to him in the first mid Staffs inquiry. Here, in full recognition of the historical fate of his distinguished predecessors, is his poignant and lawyerly plea:

The experience of many previous enquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent. It is respectfully suggested that the subject matter of this Inquiry is too important for it to be allowed to suffer a similar fate. [Executive Summary, Introduction, Page 18]

Joined up

Those who watch the Mid-Staffs corporate website will have spotted that the chief executive's pious expressions of regret in response to the report (boiler-plated by nearly every other tear-stained trust Communications Department in England) were, by 16 April, replaced by the unelaborated statement that Monitor had appointed Joint Trust Special Administrators to oversee the running of the hospital. There are two messages here. First, Francis was clear and correct, but naive, in believing that in the new transparent NHS we will rebalance the relentless good news agenda and clip-art smiling faces with his preferred focus on where we're not doing quite so well. Second, in a delicious juxtaposition that confirms the continuing absence of joined-up thinking between Monitor and the CQC that was a leitmotif in the investigation, and resulted in Francis' well-considered single structural suggestion – amalgamating the two evidently dysfunctional quangos (and which was rejected for obvious reasons by a government that needs a major separate NHS commercial arm) – the very next day the Director of Quality and Patient Experience at Mid-Staffs issued the following sunny vision:

We are delighted by the extremely positive results of the CQC Inpatient Survey, which show statistically significant improvements across a wide range of areas of care, as well as showing that we are at or above the average for most categories.

And demonstrating the same misuse of statistics to falsify the real state of patient care that Brian Jarman, a welcome and distinguished contributor to this issue, has spent years trying to change. (Heather Wood, who also writes for us, experienced first-hand the dysfunctionality of the CQC – reassuringly, according to Francis, 'not a happy environment to work in'.)

The industrious wasteland

Robert Francis' diligence is an unarguable feature of the report. His scholarly and sober writing runs throughout the 1800-page main report; even the Executive Summary, running to 115 pages, bears his stylistic hallmark. However, he isn't telling us why he appointed 4 independent assessors at a very late stage (November 2012) to help draw up the recommendations, though he must have known that they, and not his text, would have been the source for the government's response and action. Whether or not the secretary to the inquiry, Alan Robson, seconded from the Department of Health, influenced the tone of the final report is not known (Brian Jarman has expressed concern), though subsequent promotion to a senior civil service post after participating in a high-level inquiry is not unheard of.

Whatever the politics of the inquiry, the relentless leaching of nuance and emphasis in transition from countless pages of written, oral and supplementary evidence to a superficially penitent but hard-nosed government response with a characteristic sentimental title (Patients First and Foremost) has resulted in a scorched-earth landscape of maddening management-speak, interspersed with Boxed case studies illustrating sexy new interpersonal techniques, mostly unproved, such as Schwartz Rounds, Restorative Supervision and their interminable local variants ('See it my way', 'Proud to Care'; we had 'The Productive Ward' for a few years at our own hospital, until, like all such fads, it was quietly dropped.) This is surely not what Robert Francis so eloquently intended at the end of his first report, and repeated in his introductory letter in the second ('patients must always come before numbers'), and, I suspect, in part is what angered and bemused Julie Bailey and her valiant colleagues in Cure the NHS. However, he did not help the inquiry or his own discomfiture by so narrowly interpreting its scope:

*[it] includes, **but is not limited to**, [my emphasis] examining the actions of the DH, the local strategic health authority, the local primary care trusts,*

Monitor, the CQC, the HSE, local scrutiny and public engagement bodies and the local coroner.

One of the consequences of its unnecessarily blinkered legalistic remit is the expectation, richly fulfilled, that the recommendations mimic the inquiry's tone. Try this brace of mind-squirming recommendations as examples, the first a meta-, the second a meta-meta-requirement (Box 1):

Box 1
Easy to understand recommendations

14 The regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards

15 All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect.

Culture lite

Everyone, apparently, agrees that 'culture' caused Mid-Staffs. In this issue, Geoff Mitchell tackles 'culture' from the consultants' viewpoint. Francis certainly believed culture was a huge problem; it's mentioned over 600 times. However he often mistakenly believes that culture belongs primarily to high-level formal organisations (a Trust, the NHS) and therefore takes the apparently logical but hazardous step in concluding that it is amenable to treatment with centrally-dispensed cultural prescriptions. Davies and Mannion point out in their subtle analysis in the BMJ of 1 March that any large organisation comprises a 'mosaic' of cultures, and in the NHS one could convincingly argue that the ward-level culture advocated by Geoff is more relevant and important to individual patients than grandiose and vaporous statements on 'safety culture' or the 'culture of compassion' (which are not primary beliefs of doctors or nurses anyway).

Given that 'culture' is held to be central, the inquiry (and the post-inquiry seminar on Organisational Culture) disappoints by not taking evidence from academics with an interest in the complexities of organisational culture. Whatever the constraints Francis imposed within the inquiry itself there was no reason to maintain these in the seminars. (In passing I note two other participants: Victoria Simpson of the John Lewis Partnership, which would genuinely seem to have much to offer the NHS in better customer care (though I don't expect the profit-sharing bit, which may be tangentially related to JLP's excellent customer care, will soon become part of NHS policy); and the grimly appropriate managing director of nuclear [sic] at EDF energy [sic], whose advice on regulation should naturally be mandatory reading for a system in meltdown.)

While the inquiry was in session Francis received reports of serious allegations and requests for investigations from other organisations, and while he could not properly have investigated them, by taking broader evidence on related NHS failings in the previous decade or more – none of which was explored more than tangentially in the inquiry – there was a small chance that the government's response might have thereby been less sclerotic. Davies and Mannion believe that the conclusions reached on 'culture' are crude and may falsely reinforce the tenuous link between 'culture' and performance, and lead to a Manichean divide between failure and simplistic self-congratulation, both of which predispose to poor care.

The cultural weather centre

Several pseudo-quantitative measures of culture are praised in the government

response; for example SCAPE (Safe, Clean And Personal Every time) appears to have dramatically reduced harm as measured by the 'safety thermometer', which is a measure of rates of pressure ulcers, falls in care (which relates to people toppling over in wards rather than reductions in care standards, though after Mid-Staffs one can never be certain), catheter-associated infections and treatment for new venous thromboembolism. The silly name implies that real safety is the target here, but of course as with every target the 4 constituent measures will be prioritised and gamed at the expense of other aspects of safety, especially as it is to be linked to a CQUIN financial incentive. There's a cultural barometer too, and one can envisage a whole tool box of meteorological equipment guaranteeing great outcomes, while at the same time giving almost unlimited scope for spin, dissimulation and mendacity.

Oases of commonsense

In the midst of this wasteland of 'if you can't measure it, it doesn't exist' recommendations, there are, thankfully, a few oases of clinical good sense, and I would love to know who drafted them (Box 2). But these are outnumbered at least 5 to 1 by engraftments on and tinkering modifications to 15 years' worth of largely discredited command and control regulation and performance micro-management.

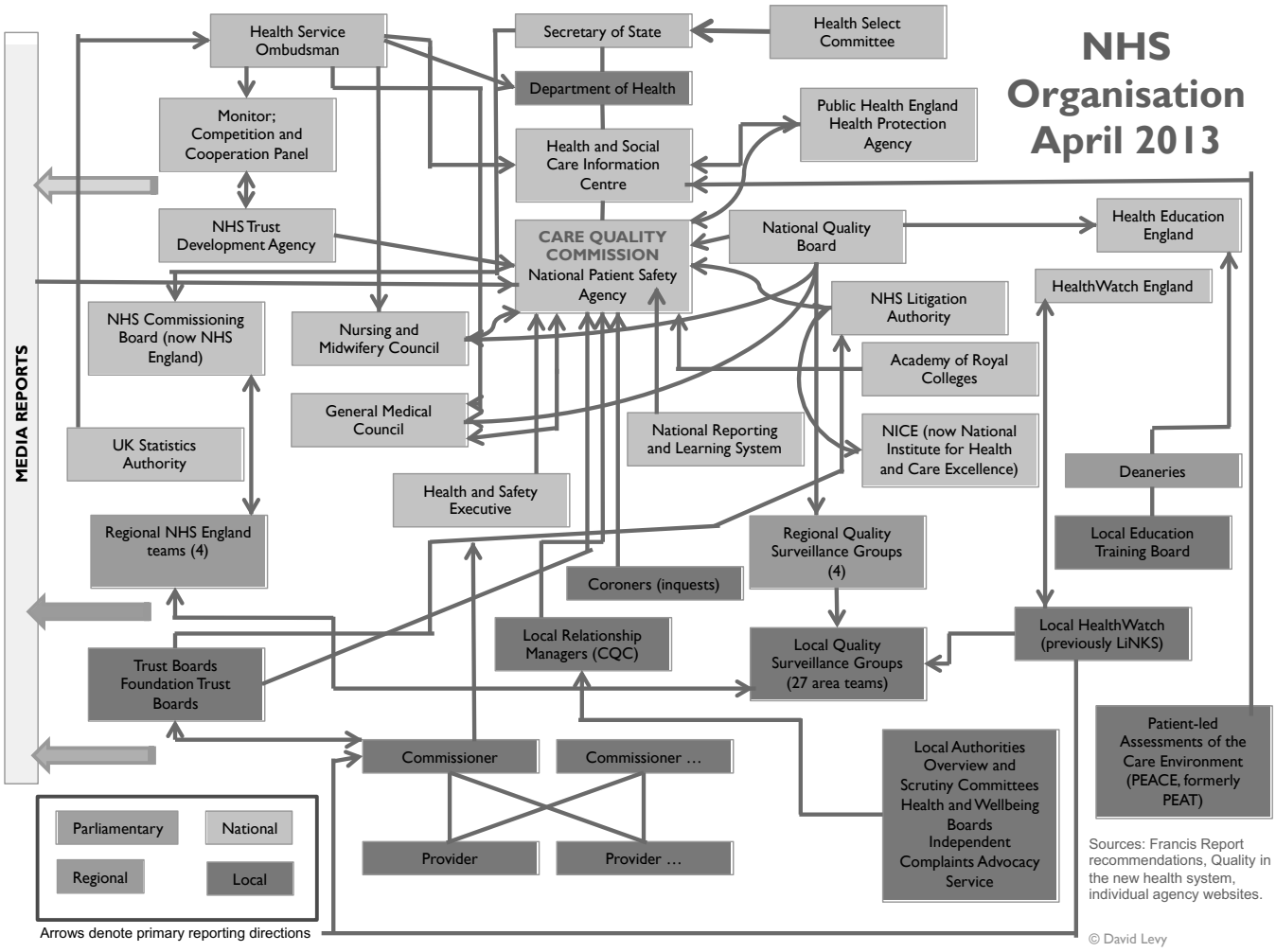


Figure 1

The new NHS organisation, April 2013

Box 2
Green shoots of commonsense

Recommendation 195 Nurse leadership. Ward nurse managers should operate in a supervisory capacity, and not be office-bound … They should know … the care plans [of] every patient …

236 Caring for the elderly [especially]. [Consider reinstating] the practice of identifying a senior clinician in charge of a patient's case, so that patients and their supporters are clear who is in overall charge.

238 Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients.

The NHS should develop a greater willingness to communicate by email with relatives

239 The care offered by a hospital should not end merely because the patient has surrendered a bed.

242 Medicines administration [special care to ensure that patients have received prescribed medication and there are no discontinuities in administration if a patient moves to a different ward]

243 Recording of routine observations [should be automatic and viewable electronically and centrally]

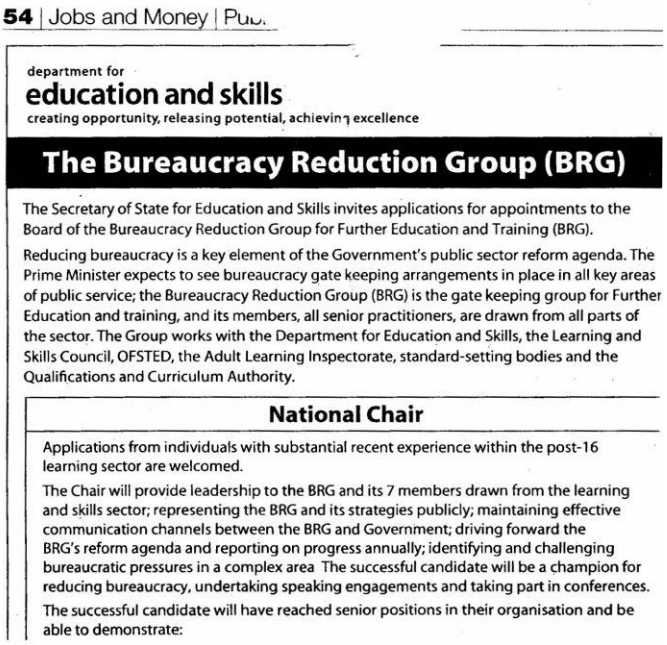
The single version of the truth

The new Chief Inspector of Hospitals (within the CQC) will become the health service equivalent of the Chief Inspector of Schools under OFSTED. This 'powerful' person will arrive at – wait for it – a 'single version of the truth', through the trusty biblical tool of 'shining a light', though his or her sword of truth will be emblazoned with the rather more earthbound mottoes of 'balanced scorecard' and 'assessment'. This is NHS management as fantasy (with a worrying hint of added authoritarianism, implying that the CIH will have the final, uncontestable, word), but is at variance with the report's recommendations, which, far from unitary pathways of regulation and enforcement, describe a system of tentacular complexity, with broadly speaking every organisation informing all the others about everything (Figure 1). It is not plausible, and possibly deeply unsafe, that this insatiable information-sharing machine can feed multiple mini-truths into the unhappy CQC to integrate into a grand universal truth, but this seems to be what is seriously being proposed. It's hardly surprising that no official version of this lurid diagram (which must exist somewhere) has been press-released.

Box-ticking to fall for the 20th successive year

My final example of organisational hubris from the government response is the delusion, innate to and as old as bureaucracy itself that form-filling, regulatory returns and box-ticking can and will be reduced, this time, though, with a target (of course) of at least one-third, through a review by the NHS Confederation. How this can be seriously countenanced (or even measured) given the massive increased demands on data production and sharing in the new NHS bureaucracy is a mystery. One of my treasured finds is a Guardian advertisement from 2005 for a Chair of a higher education Bureaucracy Reduction Group (BRG) (Figure 2). The road to its demise is obscure, but its website was launched in May 2007, and was a legacy in the National Archives by 2008. Evidently the irony of bureaucracies to reduce bureaucracy was inapparent to humourless New Labour and we can have no confidence that anything will change with this exhumation of a worn-out idea. The only way to control our minutely ingrained paper-pushing mentality and its

associated hugely expensive failure demand is to trust and enable local professionals to achieve it themselves (because the bulk of mindless paperwork has been generated at trust level). But the ratcheted-up fear induced by the report (which I'm sure wasn't Francis' intention) can have only one outcome: a further acceleration in 'safety'-related (backside-covering and blame-shifting) bureaucracy, for which there was copious dispiriting evidence given at the inquiry. The paradoxical bait here is the 'earned autonomy' of such successful institutions as Mid-Staffs on becoming an FT, in which well-behaved organisations will be more rapidly freed of the regulatory burden; less well-functioning trusts will have to devote more time and finances to feeding the beast when they would likely be disproportionate beneficiaries of a regulatory environment scaled down to essentials. Nothing will give me greater pleasure than reporting back on the progress of the NHS Confederation Review of Bureaucratic Burdens.



54 | Jobs and Money | Pu...

department for
education and skills
creating opportunity, releasing potential, achieving excellence

The Bureaucracy Reduction Group (BRG)

The Secretary of State for Education and Skills invites applications for appointments to the Board of the Bureaucracy Reduction Group for Further Education and Training (BRG).

Reducing bureaucracy is a key element of the Government's public sector reform agenda. The Prime Minister expects to see bureaucracy gate keeping arrangements in place in all key areas of public service; the Bureaucracy Reduction Group (BRG) is the gate keeping group for Further Education and training, and its members, all senior practitioners, are drawn from all parts of the sector. The Group works with the Department for Education and Skills, the Learning and Skills Council, OFSTED, the Adult Learning Inspectorate, standard-setting bodies and the Qualifications and Curriculum Authority.

National Chair

Applications from individuals with substantial recent experience within the post-16 learning sector are welcomed.

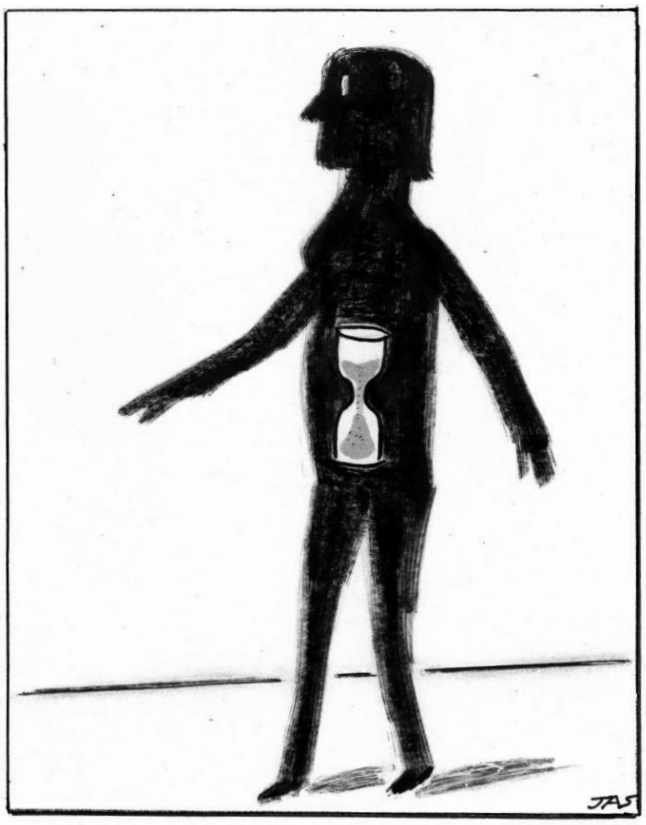
The Chair will provide leadership to the BRG and its 7 members drawn from the learning and skills sector; representing the BRG and its strategies publicly; maintaining effective communication channels between the BRG and Government; driving forward the BRG's reform agenda and reporting on progress annually; identifying and challenging bureaucratic pressures in a complex area The successful candidate will be a champion for reducing bureaucracy, undertaking speaking engagements and taking part in conferences.

The successful candidate will have reached senior positions in their organisation and be able to demonstrate:

Figure 2
Bureaucracy reduction in 2005

Another good thing, possibly

In this Atacama of deadening prose and dressed-up tired ideas, there is one more good thing: public interest disclosure, where the government has gone further than Francis. His view was that 'staff who speak up about problems *should* be supported, not vilified'; the government (2.38) seems unequivocal: 'staff [who] speak out in the public interest …*must* be celebrated and rewarded, even if following investigation the concern turns out to be misplaced' (my emphases). I doubt we will ever see this (and David Hands in the 17 April BMJ paints a distressing array, experienced first-hand, of methods of suppressive corporate skulduggery that will ensure minimal numbers of professional concerns ever make it to formal whistle-blowing). However, we have some evidence base for tracking what happens: the effective banning of gagging clauses (legally unenforceable in any case, says Francis, and he should know) should result in a steady trickle of closely-observed and well-argued revelations of unsafe practice by people shoved out of their posts. If, 10 years after Stephen Bolsin at Bristol, it all turns out to be empty rhetoric yet again, then it will be another reason why we can have no confidence that Mid-Staffs won't recur, that once again all the good intentions in the world have come to naught, and, critically, our patients will have suffered further unnecessary years of cleverly-disguised harm.



Newsletter Editorial Board

- Chair: Geoff Mitchell (geoffreymtchll@gmail.com)
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September newsletter

Andrea Franks will guest edit the September issue. Please discuss any half-baked ideas, fully-formed philosophical treatises and all those articles that have been brewing in draft on the C drive for the past 6 months (or years) with Andrea or any of the editorial team. As a guide, full articles usually run to about 1500 words but shorter items, particularly on current issues, are especially welcome and can often be squeezed in after the main articles have already been agreed.

Provisional timetable

We'd welcome firm expressions of intent to contribute material by mid-July, and the final deadline will be mid-August.

Content

We have introduced more graphics (cartoons courtesy of JAS of the Guardian) to the current issue. Graphics as PDFs or JPEGs are welcome, but other formats can be accommodated.

Contributors

Paul Evans is director of the NHS Support Federation

Professor Brian Jarman is emeritus Head of the Division of Epidemiology, Public Health and Primary Care, Imperial College School of Medicine and now heads the Dr Foster Intelligence Unit there. His work on hospital mortality rates and alerts about them to Mid-Staffs was central to the Francis inquiries, to which he gave extensive evidence

Professor John Jarrett worked closely with Harry Keen as a clinical epidemiologist in the department of community medicine at Guy's. His work on the epidemiology of diabetes led to the development of the World Health Organisation criteria for the diagnosis of Type 2 diabetes in 1980

David Levy has been a consultant physician in diabetes and endocrinology at Whipps Cross University Hospital (now part of Barts Health) since 1995. He has been an occasional contributor to the NHSCA newsletter

Geoffrey Mitchell is a retired psychiatrist, psychogeriatrician and forensic psychiatrist retiring in Hull in 1996. He is an NHSCA executive committee member and writes for the newsletter. He has recently completed a detailed assessment of elderly acute services for the new Healthwatch East Riding

Heather Wood was a member of the national specialist investigations team at the Health Care Commission that was the first body systematically to investigate Mid-Staffs. She transferred briefly to the Care Quality Commission until she left in August 2010. She qualified clinically and has had a long and distinguished career in public involvement in healthcare

Remembering Harry

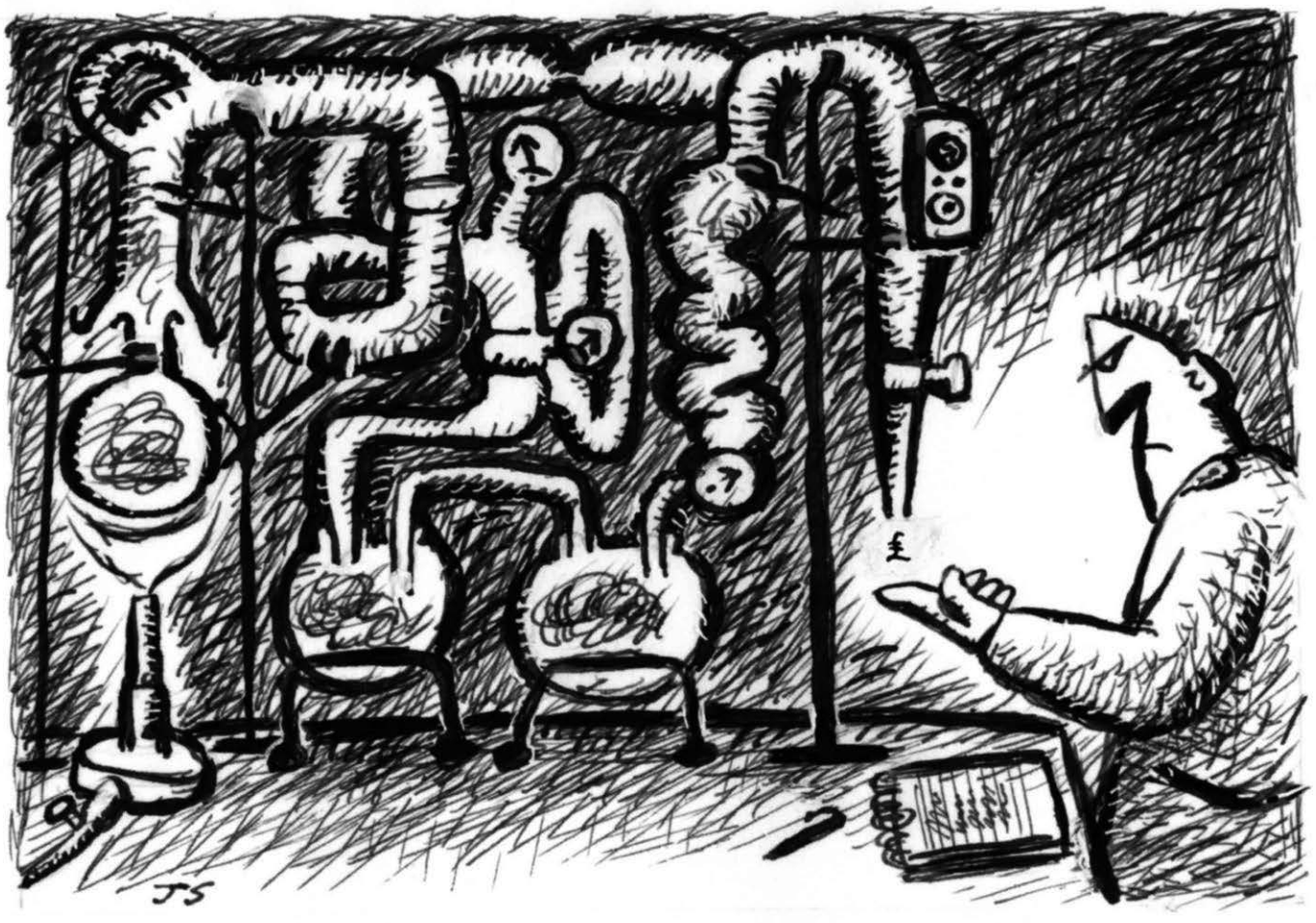
I knew Harry as campaigner. His passion for the NHS shone out and he was a truly active defender of it. In 1989 he used his influence to challenge the Thatcher government's attempt to start the marketisation of the NHS, recruiting medics to back a judicial challenge. He always recounted that the court case was lost on the basis of a misplaced comma.

Undeterred, he worked with the NHSCA to launch the NHS Support Federation with a series of full page adverts in the Observer and began the first national campaign that joined NHS staff with the public in defending the founding principles of the NHS.

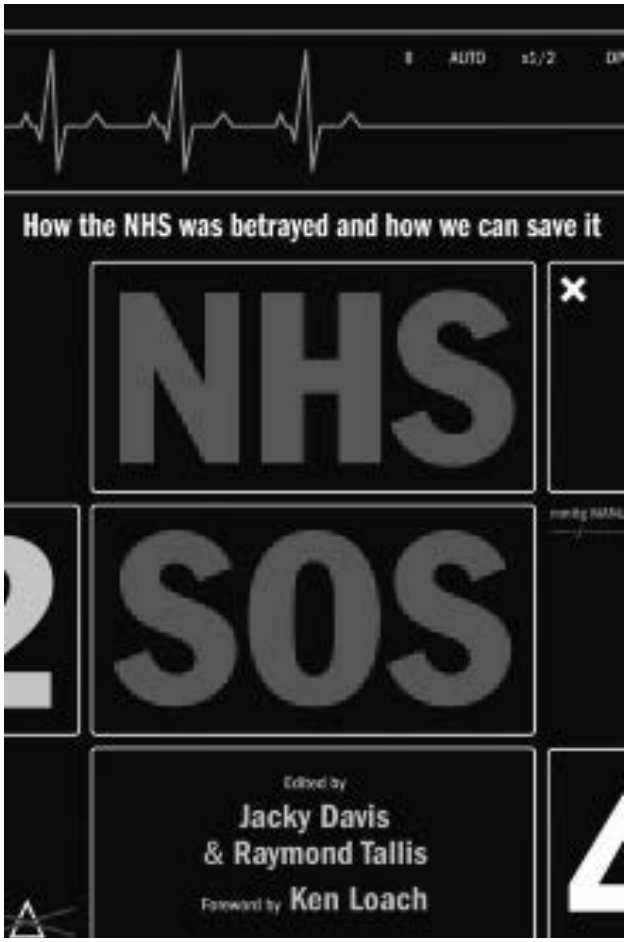
Over the next quarter century he used his wonderful intellect and creativity to support countless campaign projects, at the heart of all we did. I remember he could always muster optimism and encouragement, even though he shared the frustration of many of us that our efforts didn't always gain traction at the political level.

I wasn't the only glassy-eyed witness to his speech after the passing of the health bill last year. He inspired us at a low point and we all rallied. Soon after, he surprised us by stealing scenes in the Ken Loach film, Spirit of 45. Both showed his ability to tell his own story that illuminated his personal devotion to the NHS. He inspired so many to continue to support and fight for it. We will do our very best to honour his memory and fight on.

Paul Evans



NHS SOS:
How the NHS was betrayed and how we can save it



£8.99. Publication date 5th July 2013

Can I encourage everyone to buy - and preferably to read - NHS SOS, this summers must read book about those who betrayed the NHS.

http://www.oneworld-publications.com/nhs

It focuses on the failure of politicians, the media and the medical establishment to stand up for the country's most highly valued institution, which is now being treated by the government like a car boot sale.

The book is co edited by Prof Ray Tallis and myself, and as well as chapters by us has contributions from such luminaries as Allyson Pollock, John Lister, Stewart Player, Olly Huitson, David Wrigley and Charles West. Profits - if we manage to make any - will go to KONP, so not only is it a fascinating read but it's also money well spent! Thanks as ever for your support for the organisation and the NHS.

Jacky Davis

CONFERENCE 2013
call for members with special experience

One of the important topics we will be debating at this year's Conference will be how we can best avoid the destabilizing of NHS institutions in an era of increased competition and privatization.

A key element will be the role of Clinical Commissioning Groups and we are very keen to hear from any of our members who have taken on the role of consultant member of a CCG.

Could anyone able to help please email nhsca@pop3.poptel.org.uk

The AGM and Conference 2013

will be held on Saturday 12th October at
Bedern Hall, York

NB NOT on 5th October as stated in the March Newsletter
Change of date on account of availability of venue

NHSCA c/o Hill House, Great Bourton, BANBURY, Oxon. OX17 1QH
Phone & Fax 01295 750407 E-mail nhsca@pop3.poptel.org.uk
Website www.nhsca.org.uk