NHSCA

EDITORIAL March 2013

What about shades of grey?

Relax, dear reader! No, your editorial board is not about to serialise a best-selling steamy romance to keep our lady members in perpetual suspense (or should that be suspenders?), nor is it a request received from one of you, responding to our plea for articles and comments...

No, it's a question which I'm bursting to ask as I settle to pen my editorial with glass of favourite Rioja already to hand to give me courage.

Surely it's a fair question, even from someone prone to ask too many awkward questions about the nuts and bolts of our NHS and about how clinicians and politicians, (and some of our members are both), see things and define priorities. Coming straight to the point, must every discussion about our NHS be couched in terms of Black v White, Red v Blue, (with a tinge of appropriate yellow if you are a Lib-Dem), Bevanite v Blairite (oops! that should read Cameroon) etc.

No, I think not, although sometimes it is necessary, as was the case with Lewisham, to state that Black is Black and that no other colour will do to describe the issues. Admirably summarised by Morris Bernadt, supported by our organisation on the demo and with a financial contribution to the fighting case made by John Lister, "Saving the Cancer, Sacrificing the Patient", Lewisham has been, and remains unequivocally a fight about money, a PFI scandal and the sacrifice of a well-run local hospital. A recent "Private Eye" (No1333) gave it front-page prominence highlighting the scale of the price tag with estimated short-term costs already £331m and a total estimated bill of close to £750m, with plans to sell some of Lewisham's property assets not coming close to off-setting these costs.

But is Lewisham typical of what the rest of England can expect as battle-lines are drawn?
Are reconfiguration plans elsewhere inevitably flawed and always a "smokescreen" for cuts? Is it just possible that some proposed cuts to services (it takes the courage of Rioja to dare to use that c- word) are long-overdue and justified on clinical grounds, allowing concentration of scarce medical and nursing staff into larger units to provide better standards and more safety on a 24 hour basis? Is "centralisation" (another bland and worrying euphemism) necessary and to be welcomed sometimes? Are some issues shades of grey?

A Daily Telegraph article by Adams and O'Mahony (5/10/12 "Wards in a fifth of NHS hospitals face the axe") informs us that the Royal College of Physicians is "leading a major review which could call for large numbers of hospitals to be closed and that the other medical colleges are broadly in favour of centralisation". Could RCP be in the pocket of DOH? I hope not. There must be a certain logic to this review and the reported claim surely? Reading on, we are told that heart attack survival rates have risen by 20% in east Lancashire following A&E centralisation. It appears from comments attributed to Prof. Alan Maynard in the Lewisham article that there is indeed agreement that stroke and cardiac patients get better care in specialist units but that the case is not made for A&E or maternity services, presumably not solely on grounds of convenience and the particular problems facing rural communities. It would be helpful to have references to support the claims.

Is it inevitable that a cut in beds and increased pressure on remaining beds must lead to a deterioration in the service provided in an acute

general hospital? I can hear the moans before I go any further—"He's had too much Rioja already—let's go to bed" Well, as a long-retired consultant who worked in a somewhat atypical speciality up until the mid-1990s where psychiatric beds required to be lost to make way for a new era of community–based units (summarised in a superb article by Dick Symonds in this issue), I am not really in a position to comment about acute general hospital pressures. However, I can vouch, from personal contact with a local service, wearing my official local LINk scrutiny hat, that it is possible.

Within Hull Royal Infirmary, an acute general hospital, a truly excellent service is evolving, featuring close pre-admission screening, daily extended ward rounds with MDT evaluation, comprehensive staff training and capitalisation on Government financial initiatives, focussing initially on over 75s dementia patients but with plans to extend to general wards and the over 65s patients. Dan Harman's account is well worth studying and I am sure he will be only too happy to flesh out management details to interested colleagues. Indeed, so impressed am I by these and other innovative ideas that I intend describing the key clinical features in the next newsletter when David Levy will be inviting us to discuss the Francis Report. Incidentally, to whet your appetite, I suggest you consider the reflections of Robert Elkeles and Malila Noone, written before the Report became public.

Turning to another important issue, aired in his usual forthright style by Mark Aitken, has he made a Black and White case against becoming a FT governor? Perhaps not. He certainly spills the beans on what has happened to him and ruthlessly exposes the flaws in the system which can make Governorship a thankless and frustrating experience. At the same time his criticisms allow those of us contemplating taking the plunge to ask the appropriate questions of our local Foundation Trust. If you wish to know more before deciding, there is an excellent 20 page practical guide to influencing decision-making in an FT produced by UNISON "Stronger Together" (unison.org.uk/ournhs), which describes what to look out for. It is worth noting that there is the opportunity provided under the HSC Act to challenge the amount of income made from private patients and to challenge the trend towards a business model with powers to hold Non-executive Directors to account.

Or why not contemplate joining and becoming active in your Local Healthwatch, even with its independent patient voice currently under threat and about to come under the financial umbrella of your local authority as it evolves from local LINk from April 1st?

Moving from the strictly clinical to the political, what have our politicians been up to? Well the Labour Party can't deny that it has shown repeated shades of grey in the past, with Dobson, Milburn, Reid and Burnham contributing towards the problems now facing the NHS over PFI's, GP contracts and Foundation trusts. The Lib-Dem members of the Coalition are firmly on record as displaying a lack of fibre in the fight over the HSC Bill and we shall not forget that.

Presently, we are being subjected to rehearsals of manifesto lines for 2015 and shades of grey abound with sound bites posing more questions than offering answers. At the launch of his Party's "Whole Person care" policy Burnham announced "The NHS will be the preferred provider in a managed system"---"market –based systems are more expensive than the NHS but there must always be a role for the private sector"---"We will repeal the HSC Act". Hopefully these and other sound bites will be clarified in a meeting requested by your EC.

Lord Owen has registered an NHS (Amended Duties and Powers) Bill challenging removal of the democratic and legal basis of the NHS, intending to seek reinstatement of the duties of the Secretary of State, and repeal the duty of autonomy etc. The recent press launch emphasised that this was a short bill "with a main aim of testing the proposals by public opinion in by-elections and in a General Election ready for a new government, allowing them to urgently put it before both Houses of Parliament and enact it within the shortest possible period, hopefully no more than three months".

The Bill is supported by Allyson Pollock and Clare Gerada, two stalwart supporters of the

NHS and doughty fighters against the original Bill as we have been proud to report in earlier newsletters. Unfortunately the amended Bill has the ring of closing the stable door on a bolted horse which is about to be fed and watered.

We gave editorial status to the NHA party in our last newsletter with Richard Taylor summarising it's background, aims and principles. Members will no doubt be busy defining how best to use inevitably limited resources in tactical voting at by-elections and at the General Election.

So what's the message as I finish my Rioja and pop off to bed? Nothing very profound really, but more a plea that we get involved in debating and resolving all the issues which our changing NHS is having to face, not just from government but from having to manage the challenges of an ageing population, of pressures on local hospital services to meet standards on a 24/7 basis, of the understandable pressures to rationalise and centralise certain specialist services, of the need to ensure that we have a voice in important decision making at all levels, whether it be as Governors, or as representatives of our Local Healthwatch, fighting to protect services, standards and the basic rights of our patients and their carers.

Politicians might try to convince us it's all a matter of Black or White, Red or Blue. I'm not so sure. There are many shades of grey. If you still don't believe me then look out for E.L. James' next title---"**Darker** Shades of Grey"---but before rushing out to buy it please first have a good look at what the Francis report says. We shall be discussing it fully in the next newsletter!

GEOFFREY MITCHELL
Guest Co-Editor

Lewisham Hospital protest march

Two PFI contracts signed in 1998 resulted in the South London Healthcare Trust (SLHT) spending 16% of its annual income on servicing these contracts. The buildings consisted of new hospitals in Farnborough, Kent and in Woolwich, London. The SLHT had been overspending by £1.3 million per week and went bankrupt. The special administrator Matthew Kershaw called in to deal with the SLHT problem decided that the solution was to cut services at Lewisham Hospital which had nothing to do with the SLHT. His proposal involved the closure of Lewisham A&E unit with it becoming a GP emergency centre, the closure of the intensive care unit, the downgrading of the hospital maternity unit and the sell-off of 60% of the hospital land and buildings. Hundreds of staff would lose their jobs.

Clinical justification for this measure chimed in with a paper from NHS London entitled "Adult emergency services: acute medicine and emergency general surgery. Case for change". The message from this paper is that large A&E departments have a lower mortality rate. This is associated with better staffing at weekends (when mortality is higher compared to weekdays), having consultants freed from all other duties than emergencies and having on site specialist skills such as laparoscopic surgery. It is established that stroke and cardiac patients get better care in specialist units, and it is the case that Lewisham Hospital patients with these conditions were and are treated elsewhere. However, apart from heart and stroke, Alan Maynard has disputed the evidence showing that large A&E or maternity services necessarily have better outcomes. Immediately before the protest march there were letters to the press, for example from Mike Farrar of the NHS Confederation and co-authors, suggesting that those who opposed the change were ostriches with their heads in the sand. In respect of Lewisham Hospital these letters ignored issues of capacity and distance for Lewisham residents. That is, the A&E departments at King's College Hospital and Queen Elizabeth Hospital in Woolwich are already overstretched with lengthy queues and it would involve catching three buses for an individual e.g. a mum with small children to get from west Lewisham to the hospital in Woolwich. Saturday 26th January 2013 was a bright sunny

day and the colourful procession with banners, balloons, whistles, vuvuzelas and drums represented a diversity of organisations opposed to Kershaw's plan. Newspaper estimates of the numbers on the march ranged from 10,000 to 25,000. Those from the NHSCA whom I saw were Jonathan Dare, Jacky Davis, Malila Noone and, under the NHA party banner, Richard Taylor. A comment about our banner was that the writing is too small. The main party set out from the Lewisham rail station and marched past Lewisham Hospital to Mountsfield Park where there were speeches, music and refreshments. A prevalent theme was that whatever the outcome of Jeremy Hunt's decision the following Friday, action to retain existing services would continue.

Hunt had statutory requirements to meet before making a major service change: to get local clinicians to agree which they did not; to consult with the public, patients and local authority which elicited vehement opposition; to present clinical evidence in favour of the changes rather than managerial factoids; and to ensure that any change gave patients a choice of "good quality providers" though what the patients wanted was Lewisham Hospital. The BMA commented that the consultation period was too short. In parliament Hunt announced that following discussion with Bruce Keogh, the NHS medical director (who had earlier written about ostriches with their heads in the sand), he had decided to compromise. The A&E department would remain a 24/7 service, though handle about 75% of its former patients with more serious conditions being treated elsewhere, but the maternity unit would, as originally planned, change from being obstetrician-led to being a midwife-led birthing centre. Hunt had accepted six of Kershaw's seven proposals. Protest groups described his compromise as being a whitewash, particularly in respect of the ill-defined A&E change – how would "more serious conditions" be determined? A slide to an emergency centre is predicted. A fortnight later Steve Bullock, the mayor of Lewisham announced that Lewisham council is to seek a judicial review on the grounds that Kershaw, who had been charged with finding solutions to the financial problems of the South London Healthcare Trust, had exceeded his brief by proposing changes to Lewisham, a financially viable hospital. "I do not believe the Trust special administrator had the statutory power to make recommendations about Lewisham Hospital and the secretary of state therefore has no power to implement them".

In all, 26 A&Es across England and Wales are currently under threat of closure.

MORRIS BERNADT
Psychiatry

The Mental Health Service in England

While I realise the tendency of the retired to bemoan all developments since they left the stage, nevertheless I have felt for some time that the mental health services, in England and Wales at least, peaked in efficiency and effectiveness sometime in the mid 1990s, and have started to decline in many aspects. This is based on my observations of the mental health services from the underside, as it were, in carrying out the duties of a medical member of the Tribunals Service, in the south-east. (I am speaking mainly of the mental health service for the adult age range.)

History

Britain has a long history of tolerance and care for the mentally ill. Fifteenth century England made specific state provisions, as a duty of the sovereign, to care for the mentally handicapped and mentally ill. While the prevalence of the major psychoses has probably remained the same for centuries if not millennia, the population explosion of the industrial revolution made the absolute numbers of psychotics apparent and spurred the state to provide services - or containment. After the 1601 Poor Law, services

for the mentally disordered were largely provided by the developing municipalities, apart from the few famous asylums and 'mad-houses' for the mentally disordered rich. The county councils provided and ran the asylums of the mid to late 19th century. The National Health Service of 1948 at a stroke, incorporated the municipal and county provision and made change from poor law containment to a medical service. The increasing number of doctors evolved into genuine physicians for mental disorder, rather than the pejorative 'alienists'. This process culminated in the 1959 Mental Health Act, the most humane and advanced mental health legislation in the world at the time.

Even in the early 19th century asylums, some patients made spontaneous recoveries and were discharged. By the 1960s, however, these institutions, now 'mental hospitals', were containing up to four times the number for which they were originally provisioned. Fortuitously, at this point, came the beginning of the true psychiatric treatments, the anti-psychotics and electro-convulsive therapy, which dramatically reduced bed numbers, only to be re-filled by the same patients months later, later known as the 'revolving door'. It was clear that extra-mural services were required, leading to the development of out-patient clinics in general hospitals, Day Hospitals, and later the full panoply of 'care in the community'. The asylums needed to be closed: they were foul and disgusting places in which to treat our citizens and many of them were literally falling down with age. Scandals in the ill-treatment of patients in the mental hospitals hastened their closure. The Conservative government of the day, with a shrewd eye for the potential of large asylum sites, let them go for pittances to private developers, without re-directing the profit to community services.

Labour's 1975 document 'Better Services for the Mentally Ill', demonstrated a comprehensive multi-disciplinary service, based on general hospitals. In the philosophical zeitgeist well-meaning US and UK writers of the libertarian left tried to prove a connection between society's structure and serious mental illness, which to this day is what much of the media understands by causes of mental illness. Sadly, this led to the rubbishing of mental health professionals and the families of the mentally ill, and to opposition to the improvements in pharmacological treatments. The improving 'mental health teams', now often operating from community bases, were also influenced to 'treat' much less severe mental disorders and even social disorders, manifestly because they believed it would be preventative, latently because these patients were easier, transient and usually grateful. The same process in the USA and in other European countries, realised 'Care Management', the identification of the severely mentally ill who were to be the highest priority for care, and the necessary planning to do this. In 1991, the UK Departments of Health and Social Services , put out twin papers on the 'Care Programme Approach' (CPA) a simple, pragmatic and operational guideline for operating a system of dispersed psychiatric multi-professional care and treatment.

Three other important concepts developed in the NHS, mainly in medical professionals: scientifically-based medical evidence as the basis for treatments; the systematic clinical audit of services; and particularly in the mental health services, the assessment of risk. As with the scandals in the hospitals, so publicity given to a small number of prominent homicides by the mentally disordered, led to the high-lighting of security and safety, resulting from patients perceived to be improperly in the community and not in hospital.

In the wider NHS, by this time, all was not well, general organisational and political developments having been set in motion that would include the mental health services. The first of these was the 1985 Griffiths Report, which produced a corporate management system ending the felicitous collaboration of health professional and NHS administrators in running the service. Quasi-industrial 'managers', rapidly assumed the role not just

of running but directing the NHS, without much clinical input. Secondly, NHS Trusts were imposed as the units for governance of the NHS, with the wholly artificial model of the 'purchaser-provider split', in which some elements of the service played at buying and others at selling. Sadly the New Labour government had little intention of putting the service back where it belonged.

Mental Health Services, the Zenith

By the mid-90s, most of the mental hospitals had closed and the normal place of treatment was the new psychiatric unit in or attached to the general Hospital. The long-stay patients of the mental hospitals had been discharged to a variety of residential care facilities, some entirely NHS and highly staffed. Psychiatric consultants in the new units were simply consultant colleagues in the medical and surgical body and a few became chairs of medical staff committees. The focus of psychiatric attention switched to the mental health multidisciplinary team often working from a community mental health centre as team base into hospitals rather than from hospitals to the community. Mental health services became localised and accessible. The consultant was the recipient of GP referrals, responsible for deciding who would assess the patient. Teams, including the consultant, would meet weekly, both in the ward and in the community to deal with problems. The service was geographically 'sectorised', meaning that a consultant-led multidisciplinary team would adopt a wedge of the catchment population, and thus be fully cognisant of the social and economic characteristics of their area and this started to lead to an epidemiological approach to mental disorders. It also encouraged continuity, so that the patients with the typically long-standing problems could feel supported and be thoroughly planned for under the CPA. Training for psychiatrists was led by the Royal College, and was the envy of other medical disciplines, with keen clinical tutors organising weekly teaching sessions. The Mental Health Act guaranteed legal safeguards for those who needed involuntary detention.

The Labour government introduced 3 measures of importance to mental health: the Human Rights Act (a mental health patient was its first cited case); NICE, the National Institute for Clinical Excellence, which took a properly scientific attitude to the proliferation of psychotropic drugs; and the National Service Frameworks, of which mental health was the first. Computerised case registers were devised. Clinical Audit was carried out into local services, and nationally into suicides and homicides by mentally ill people. For the first time for decades morale in the service was high.

The downhill slide

An insidious deterioration has followed this peak and I believe resulted from Thatcher's reforms. By the new millennium the managerial revolution in the NHS could be recognised. Highly trained clinical staff mutated into untrained 'managers', with a net loss to the service. Endless manuals , directives and guidelines were generated. With little evidence base, they changed a professional and clinically led intelligent approach to our work into the bureaucratic following of procedures. Meaningless woffley 'management speak' became the norm. The championing of individualism over collective approaches made 'choice' the prime concern for management, but least relevant for the mentally ill. The attack on professionalism, begun by Thatcher, denigrated all professionals, particularly consultants. The need for units of the NHS to bill and pay each other led to financial bureaucracy and waste of resources to accounting, rather than saving (recently confirmed by a Commons Select Committee). The concern with cutting at all costs, to meet an entirely artificial internal NHS tax, has led to disruption of well-functioning services. Thousands of acute in-patient beds have been sliced away across the country, so that in-patient units are only for those who must be admitted at all costs, usually because they are both psychotic and homicidal: in-patient wards have once again become scary places. Beds are again extremely scarce in the cities. In Kent the three asylums of the 19th century,

replaced by seven local units, are now about to be replaced by three hospitals, each on the site of the old asylum. The Mental Health Act has been misused by some county councils so that they will not have to pick up the bill for after-care, and inevitably the proportion of detained patients on wards, previously 15%, has risen to an average of 50%.

Tertiary care is often essential for the long-term mentally ill. No longer is it possible for one consultant to refer to any other. Valuable resources are now wasted in funding-panels who rarely accept the expertise of the local team, and fund the cheapest rather than the correct option.

The process whereby everyone knew better what was needed for mentally ill people than trained clinical specialists, reached its acme when the New Labour Government began to 'badge' services which it fancied, thus shattering the carefully built up mental health teams, into a cloud of acronyms, but with no increase in staff. Without national consultation or evidence, managers concerned about in-patient standards, once again divided psychiatric hospital wards from their community by appointing separate consultants to each.

Electronic case records, which could have offered so much as the nervous system of a dispersed service, collapsed nationally, and locally are less available than the written case records and seem to function only defensively.

The early NHS Trusts concentrated on surgery at the expense of disciplines like psychiatry, with the result that Mental Health Trusts were created to reserve resources, once more separating psychiatrists from their medical colleagues. Mental Health Trusts then merged into giant bureaucracies, which seemed peculiarly susceptible to managerial authoritarianism, with the consequence that consultants are often cowed, passive and defensive. Practice has become more slovenly, clinical case notes poorly written, GPs forced to refer to nebulous teams, rather than to a doctor. The CPA is observed in word only. After falling for decades, the UK suicide rate is now rising, following the 2008 bank collapse. Diane Abbott recently noted: "for the first time in a decade we have seen a cut in the total spending on mental health... what we're seeing is a staff shortage crisis, vulnerable people not getting the help, respect and dignity they need and crucial care services are withering away". Morale is low and exhaustion high, at least in the acute mental health services.

The Health and Social Care Act 2012 is widely seen as the beginning of the end for the NHS: if we let it. It is particularly irrelevant to the mental health services, which historically have always been publicly provided. GPs are supposed to commission, but in reality will give over this task to Clinical Commissioning Groups which themselves will use commercial companies for implementation. The commissioning process is particularly difficult to specify for mental health services and individuals, and it will get bogged down in further bureaucracy. Individual GPs will disregard mental health patients, who are notoriously unassertive. The 'Any Qualified Provider' clause will push more patients seeking fewer beds into private institutions, whose standards are already cause for concern. Inexpert voluntary and private community services will be used because they are cheaper, 'qualified' will be widely interpreted, with the patient care and safety imperilled. Risky patients may be diverted to Forensic Psychiatric beds, and find it difficult to return to the mainstream service. Liaison with Local Authority provided services will become more difficult. The gap with other medical disciplines will widen. The Act's 'payment by results', has been endorsed by The Royal College of Psychiatrists, but there are many reasons to distrust this system, mainly because of the difficulty of specifying, and even less measuring, outcomes in mental health.

Ed Miliband recently made a speech to the Royal College of Psychiatrists in which he pointed out that mental ill health costs the nation at least £26Bn annually, yet, he said, politicians almost ignore it. Benefits to general medical services

would result from improved mental health service funding.

What is needed

Many of today's problems in England's mental health services, could be solved by the NHS returning to the *status quo ante* 1985. 'National' would once again mean all-UK. The NHS would be the provider for all health, with rare exceptions. This envisages a simpler localised service, with funding dispensed from the centre, without an internal market, run on an operational basis by professional clinicians with NHS administrators for its implementation. The NHS would assert its enormous purchasing power to drive down prices of drugs, equipment and services from without. Commissioning would be swept away and revert to strategic clinical planning, for which every consultant would be contractually obliged to assist to a specified limit(no more incessant 'meetings'!). A robust and democratic patient feedback, with delegates representing users on all NHS bodies and liaising with local government would be the third limb.

The useful aspects of what has been learnt since 1985 would be kept: that community and hospital services need to be seamless, planning should follow medical evidence, clinical audit, multiprofessional equality and NICE.

There is possibly less scope in mental health for primary prevention, but there is some. Consultants should be expected to respond to requests for education from schools, places of work, the Police and other institutions of society. Alcohol reduction, improvement of diet and increase in exercise would impact on alcoholism, depression and vascular dementia. This would demand far more of the NHS than that envisaged by the last government, one in which it would be able to intervene against commercial power, in, for example, the supermarkets. There is more scope in secondary and tertiary prevention, for example in schizophrenia, with the development once again of sheltered work programmes funded partly by appropriate benefit; and the routine use of investigative measures in order to plan remediation, taking place in rehabilitation units.

National mental health strategy must be set by expert mental health professionals working with government, not by political whim. We need a 'Good Practice loop', where innovation locally is tested centrally and then implemented. Local mental health needs should be assessed within the remit of each service, principally by the clinicians and lead naturally to local strategy. If we could return to planning bed numbers and team sizes using known indices and a geographically based service, we could improve ward standards, continuity of care and the consequent efficiency of the management of serious mental illness. With calmer wards, more therapeutic milieux could be developed, based on clinical, psychological and educational evidence.

Nowhere is medical evidence more needed than in mental health services, potentially a large black hole for funding, particularly at the milder end of the spectrum. Psychological treatments particularly should be strictly limited to diagnostically defined conditions, time limited and automated where appropriate.

The CPA should be applied more conscientiously. All new patients should be referred to the consultant and his team, diagnoses made, treatment plans drawn up and recorded in a clinical case register of the service. Longer -term and more severe patients should have care coordinators allocated by the NHS (not by the local authority) and the full care plans adhered to, with internal audit to ensure its proper operation.

Professionals need to re-assert their status. Management should ring fence clinical procedures into which they will not intrude, thus allowing clinicians to return to intelligent professional thinking – what used to be called 'clinical freedom'. The Royal College should reassert its domination over local clinical teaching and maintenance of clinical

medical standards, with the assistance of local administration.

There needs to be a much more thorough monitoring of legal aspects of the service, to ensure that patients and their relatives are being given all their legal rights and that doubtful practices are identified and questioned. Patients need more free legal assistance than that granted for the Tribunals as many are too ill or demoralised to fight for their rights. There should be a national guideline on the relation between the Police and the mental health services.

Mental health staff must not separate themselves from general health services, as human illness takes no such account. Mental health services need to return to the easy clinical contact with all medical specialities, and this can be assisted by the removal of the commercial barriers that started the present separation.

Psychiatric patients are among the poorest in the land. Benefits are essential to those who cannot work and should be dispensed, using a proven instrument, by a statutory authority and not a commercial company, to a patient assisted where necessary by an advocate.

I have spoken about only a tranche of the mental health services: those of England and not the UK, where those in Scotland appear to have so far maintained their standards; and the general adult range, ignoring child psychiatry, the elderly service, learning disability and the forensic services, yet many of the criticisms I have made, will apply in these specialties also.

DR. R.L.SYMONDS
FRCPsych

Transforming Dementia Services in the Current Economic Climate

Background

Striving to provide a comprehensive multi-disciplinary service for a rapidly growing elderly population with multiple co-morbidities has always proved challenging. Dementia is not exclusively a disease of the elderly, however it's prevalence in society is significantly higher in those aged 75 years and above. There are currently 800,000 people with dementia in the UK. This figure is expected to rise to 1.7million by 2051[1]. An estimated 25% of acute hospital beds are occupied by people with dementia[2], their length of stay is longer and more complicated than people without dementia and they are often subject to delays on leaving hospital.

The projected expansion in the prevalence of dementia, current economic climate, bed pressures and the evolution of the new Clinical Commissioning Groups (CCG) may add further to the difficulties faced when caring for a potentially vulnerable group of elderly patients.

How do we respond to such pressures? Can we simply "carry on regardless" as these issues threaten to engulf acute hospitals? Or must we look for new ways of working innovatively and collaboratively with our community partners?

Through close partnership working, Hull and East Yorkshire Hospitals NHS Trust (HEYHT) can demonstrate how services can be transformed to thrive and not just survive during such difficult times. It is hoped that other hospital trusts can use our examples of service transformation to implement changes in their own organisations.

Transforming Services

In order to transform dementia services we need to understand 3 key questions:

1. Where we wish to be (our vision)?
2. Where we are?
3. How we will get there?

1. Where we wish to be (our vision)?
Our shared vision is to provide safe, high quality, effective care for every person with dementia delivered as an integrated pathway across acute, primary and community care settings.

2. Where we are?
HEYHT serves a population of approximately 1.2 million people with an estimated 192,000 people over 65 years of age. Currently under 3000 people in our locality are registered as having dementia. This is likely to be a significant underestimate as we know there are low diagnostic rates in both of our local primary care trusts.

Inpatient care of patients with dementia is currently delivered on the specialist Elderly Care wards with daily input from colleagues in Mental Health, Social Services and therapies. The National Audit of Dementia Care in General Hospitals (2010) highlighted a number of deficiencies in the provision of care for people with dementia in HEYHT[3].

3. How we will get there?
Support networks:
To improve services, it is essential to understand the support and resources that exist at national, regional and local levels:

National Support
The Dementia Strategy and Government Financial Incentives

The National Dementia Strategy[4] identified a number of areas which must be prioritised in order to enable people to live well with Dementia:

- Early diagnosis and intervention for all
- Living well with Dementia in care homes
- Improved quality of care in general hospitals
- Reduced use of antipsychotic medication
- Coordinated End of Life Care

The National Dementia Strategy is supported by a new national goal within the Commissioning for Quality and Innovation (CQUIN)[5] framework to encourage the better identification of patients in hospital with dementia. The CQUIN framework is a quality improvement programme that "enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals" (Department of Health, 2010).

In addition, up to £50 million will be available to NHS trusts and local authorities, working in partnership with care providers, to help redesign hospitals and care home environments to meet the needs of people with dementia[6].

Capitalising on Government financial incentives such as the CQUIN framework and applying for funding to enhance the healing environment can help with service improvements at little or no extra cost to an acute trust.

The Dementia Action Alliance[2]
The Dementia Action Alliance is made up of over 100 organisations committed to transforming the quality of life of people living with dementia in the UK and the millions of people who care for them. Organisations such as acute trusts are invited to sign up to a National Dementia Declaration and submit their own action plans setting out what they will do to secure these outcomes. The declaration creates partnership with people with dementia and their carers but also makes acute trusts accountable for their commitment to improving services for people with Dementia. Future government financial incentives are likely to be linked to organisations signing up to and achieving the outcomes set out in their action plans.

Regional Support
The Yorkshire and Humber Strategic Health Authority facilitate an Acute Hospitals Dementia Champions Network for all acute trusts in the region. This network provides a platform for sharing best practice and allows trusts to learn from others' successes and failures regarding Dementia initiatives.

Local Support
HEYHT has recently established a multidisciplinary Dementia Care Program Board to ensure it delivers high standards of care for people with Dementia and their carers. The Dementia Program Board has membership from the acute trust, local mental health trust, social care, voluntary and public sectors and is therefore truly representative of the needs of people with Dementia living in our locality. With our partner organisations, we have been actively involved in developing a regional Dementia Blueprint that will allow us to deliver person-centred care that focuses on living well with Dementia.

Implementing Change
Involvement in these three tiers of support is essential to turning government initiatives into tangible local service improvements. Members of our local Dementia Program Board also represent the trust at the regional and national networks and it is this consistency in membership that ensures reliable information sharing between the networks.

Successes to date
At HEYHT we are striving to become a national exemplar of Dementia care. We have signed up to the National Dementia Declaration. The trust's action plan is now in the public domain on the National Dementia Action Alliance website[7].

We have adopted the 5 principles of the Dementia Action Alliance's SPACE approach to achieve the following service improvements:

Staff who are skilled
We are designing a mandatory trust wide training package to ensure **all** staff members receive basic Dementia awareness training with optional higher training delivered to our Dementia champions.

Partnership working
HEYHT now has an established Dementia Program Board with multi-disciplinary representation from all our local partners.

Assessment and early identification
We have designed and implemented a trust wide Dementia screening tool for all patients admitted to our organisation. This has allowed us to successfully achieve the National Dementia CQUIN target worth £1.05million and more importantly has identified many people with undiagnosed Dementia. Such people have subsequently been referred on to appropriate community services for further assessment and treatment. We are in the process of auditing the screening tool to ensure improvements in patient care are maintained.

In partnership with our Information Technology team we have developed a web-based patient tracker tool to ensure people with Dementia are cared for in the right place, by the right people, at the right time. The tool helps with appropriate patient placement and minimises the inappropriate transfer of people with Dementia when bed pressures occur.

Care that is Individualised
HEYHT has implemented the Butterfly Scheme[8] trust wide. This is a scheme that allows us to deliver person-centred care for all patients with Dementia or Delirium whilst in hospital.

To promote the use of technology in healthcare, we have worked in partnership with an external company, CAYDER, to identify patients with Dementia via a discrete butterfly symbol on our electronic whiteboards in the ward environments.

HEYHT has appointed Dementia Champions in both clinical and non-clinical teams. We now have over 100 Dementia Champions who will

help cascade the Butterfly scheme training and all Dementia initiatives throughout the hospital.

There is a national drive to reduce the use of antipsychotics in managing "behaviour that challenges" in people with Dementia. Working closely with our liaison psychiatry team we have reduced our prescribing rates. We have completed a regional audit (2013) and can clearly demonstrate that our trust now has one of the lowest antipsychotic prescribing rates in the region.

We are one of a few Acute Hospital Trusts to use Dementia Mapping in our wards to understand the deficiencies in our service from the patient's perspective. Hull's local Dementia Academy has supported us with this work and we plan to roll out Dementia Mapping in all our environments in which people with Dementia are cared for.

Environments that are Dementia Friendly

HEYHT have submitted a partnership bid worth £1million with the local City Council, Mental Health Trust, and Hospice. If successful the aim is to refurbish 2 acute wards and community healthcare settings to enhance the healing environment for people with Dementia.

Plans for 2013-2014

Our transformational work is very much "in progress" and our plans for the next financial year are to focus on staff training and enhancing the healing environment.

We intend to measure our success through markers of quality in patient safety (e.g. reduction in falls and agitation), effectiveness (e.g. length of stay and patient placement) and experience (e.g. patient, carer and staff satisfaction).

Conclusion

Clearly our transformational work focuses on improvement in Dementia services, yet this process can be applied to the management of any long-term condition. Service redevelopment can prove extremely challenging against a back drop of financial uncertainty. However with strong multi-disciplinary support at local, regional and national levels and with a willingness to think differently a great deal can be achieved.

DANIEL HARMAN
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The NHS's lot is not an happy one!

During the summer a new and refreshing atmosphere spread throughout the country. During the Olympic games our athletes excelled and the organisation was superb defying the predictions of critics. The large band of volunteers showed the fund of goodwill that was present if called for. The country felt good about itself. Alas, this feeling was short lived. It was not long before we resumed our usual practice of seeking to blame various groups for their perceived failings. The government is usually at the centre of these recriminations be it on the police, the teachers, workers at all levels in the NHS. While there are undoubted failing in the working of all these groups the generalised criticism undermines their morale and hides the really excellent work of the majority of these people and displays the lack of mature leadership or analysis by those at the centre of power.

In the NHS there is currently a spate of apparent very poor examples of care seized upon by the new Health Secretary Jeremy Hunt presumably to help him find his feet as he tries to grapple with the huge complexity of the Health and Social Care Act driven through by his predecessor. It is striking that there is a deadly silence in the media and by government spokesmen on the changes now occurring.

We have had the initial result of the Mid Staffordshire NHS Foundation Trust inquiry by Robert Francis QC. The next instalment we are told will be published in about one month from now. At the time of writing this we only have what was leaked to the press. In the findings published so far, the inquiry identified many areas eg, a corporate focus on process at the expense of outcomes, a failure to listen to those who received care through proper consideration of their complaints, staff disengaged from the process of management. Insufficient attention to the maintenance of professional standards and lack of support for staff through appraisal, supervision and professional development and many others. The inquiry also pointed to the culture of the trust in which there was an atmosphere of bullying with fear of adverse repercussions in relation to a variety of events and a forceful style of management. In addition a high priority was placed on the achievement of targets especially in A&E waiting time targets, generating a fear that failure to meet these might lead to dismissal. The consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans presumably because they felt that their views would not be listened to. There was a lack of trust in management leading to reluctance to raise concerns. Unfortunately these attitudes are not confined to the Mid Staffordshire trust and are more widespread. In leaks to the Sunday Times 6th Jan the inquiry is expected to say that NHS managers ignored and even stifled the evidence of soaring death rates. It is likely to attribute this to a desire to protect their organisation's reputation and to criticise NHS bosses for being preoccupied with turf wars against rival organisations.' Once again it is easy to lay the blame on managers. The managers are merely the messengers doing the bidding of government and Department of Health. The latter should accept some responsibility for these attitudes for promoting competition and an outdated and inappropriate business culture into healthcare. Most trusts, especially those trying to achieve foundation status only want to give good news stories and problems tend to be buried. This is what is to be expected in the pseudo commercial culture promoted by so many of our health gurus and enthusiastically embraced by politicians of all parties. What we really need is the culture of working together and co-operation promoted by highly successful organisations such as the John Lewis partnership where staff are consulted and take part in management changes. Regrettably and predictably this message will be lost on our political masters.

Nowhere are the current stresses of the NHS

more keenly felt than in our acute sector dealing with general internal medicine and the 'medical on take' These problems prompted the Royal College of Physicians to produce a wide ranging report in October 2012 entitled 'Hospitals on the edge? [1] The time for action'

There are a third fewer general and acute beds than there were 25 years ago but during the last decade there has been a 37% increase in emergency admissions. Efficiencies have reduced the length of stay but this tendency may be flattening out. Certainly the unrelenting pressure to discharge patients at the earliest opportunity may lead to a lack of compassionate care and proper provision of services for discharge. The report points to the changing nature of the patients and their needs. Nearly two thirds (65%) of those admitted are over 65 and an increasing number have dementia. Often staff are not equipped to deal with their multiple and complex needs and problems. Consultants report on the lack of continuity of care as their biggest concern. It is not uncommon for patients to be moved four or five times during one stay often with incomplete notes and poor handover. The report says that each move adds at least one day on to length of stay and has a detrimental effect on patient experience. How can nurses or even medical staff (however transient) develop a rapport with patients who are rapidly moved elsewhere? This is compounded by the lack of continuity of care provided by doctors in training. The problem here is the European Working Time Directive and the New Deal. Warnings by consultants and countless articles and letters (including two to the Times by the author) on this subject have all had, as yet, no effect. One of the most eloquent analyses of the subject was by Charlotte Leslie, Conservative MP for Bristol North West, in the Times of 20th Jan 2012.[2] She pointed out the directive to limit the working hours of junior doctors to 48 has been devastating for training and for the expertise of the next generation of consultants. Doctors in training now work a shift system and many trainees say that this is actually more tiring than the old on call system. Consultants now find that they are frequently the only people who know about the patients seen on ward rounds. Not only is this bad for continuity of care and patient experience it means that doctors in training cannot follow up patients seen and see what happens to them. This is bad for physicians. For surgeons two thirds reported that training had deteriorated since the directives had been enforced. She pointed out that arguments had become polarised between those wishing to continue the 48 week and a return to 100 hours. No one is advocating the latter. However we would all prefer to be treated by a doctor even if he/she had worked 60 hours rather than one with insufficient experience. Good training needs both theoretical instruction and practical experience with increasing responsibility under supervision. The problems which arise from this system were graphically described by Russell Hopkins a retired distinguished maxillofacial surgeon who suffered severe complications after a spinal and epidural block and received scant attention from frequently changing and inexperienced medical staff. Far more dangerous than tired doctors is the prospect of newly appointed inexperienced consultants having to take difficult decisions on their own for the first time. In addition the cost of providing locum cover has more than doubled to £800 million per year in two years and trusts spend £15000 per annum on monitoring the enforcement of these hours. Consultants themselves are working longer and longer hours. Three quarters of hospital consultants reported being under more pressure than three years ago and a quarter of medical registrars reported an unmanageable work load. Recruitment into emergency medicine is becoming increasingly difficult. Applications for training posts which involve general medicine are also declining.

The RCP [1]suggests ten priorities for action which include, promotion of dignity and patient centred care, redesign of services, changes in organisation of hospital care, medical education and training and renegotiation of the New Deal and others. Many of these are aspirational. However in his bulletin from the Royal College of Physicians on Jan 8th 2013, The President Sir Richard Thompson indicated that 'The

government has also accepted that the New Deal contracts must be renegotiated so as to increase flexibility of trainees' hours. This may make it possible to return to some sort of team structure, which will, I believe, increase continuity, improve training and raise the morale of patients and staff'. It is interesting to note that the working hours of British Hospital doctors even made it into the David Cameron's much awaited speech on Europe finally delivered on January 23rd.

In the review of the coalition's achievements by David Cameron and Nick Clegg on 7th Jan there was no mention of the NHS as if nothing had happened. The prospects for the NHS in 2013 have been reviewed in the BM 5th Jan by Professor Chris Ham[4]. The budget will grow only in line with inflation so that financial pressures will increase. Most finance officers thought that the quality of care might be adversely affected. The new bodies created by the Act are struggling to get started. As he points out a reorganisation that promised to reduce bureaucracy and streamline structures has achieved the exact opposite. In addition to the Commissioning board and its local outposts, there are Monitor, Public Health England and Health Education England and the NHS Trust Development Agency. More locally there are the clinical commissioning groups, health and wellbeing boards and commissioning support group as well as LETBs (local education and training boards). Clinical Senates which were previously mentioned seem to have quietly dropped.

I have recently been appointed as secondary care doctor on a CCG. The one to which I have been appointed is as I write undergoing its authorisation process. This is a rigorous examination of all the processes involved in commissioning. My work has not really started but I have attended the rehearsals for this. The amount of work which the members of the board have had to produce is mind boggling. It appears that most of the processes and policies of the PCTs have been discarded and CCGs have had to start from scratch. This does seem hugely wasteful. Also the loss of many experienced managers has been wasteful and damaging. However I am most impressed with the quality, dedication and hard work of the GPs who sit on the CCG. They are supported by first rate managers. The idea of Andrew Lansley that they could do all this work without huge management support was always ludicrous and so it has proved to be. The GPs all tell me that they are struggling to maintain their clinical commitments in primary care and that this load will be difficult to sustain. Their sessions have to be filled which of course adds to the costs. I will be able to give a fuller report in due course when I have more experience of how it works in practice. I can say at this stage that there is a clear policy centrally driven to move work out of secondary care into the so called community. While this may well be desirable in certain areas, the process could de-stabilise some hospitals. My role will be to present the secondary care point of view. I hope to be able to report again in the future on how the new process is working.

ROBERT ELKELES
General Medicine/Diabetes

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“Preparing for the Francis Report

How to assure quality in the NHS
Kings Fund: Anna Dixon, Catherine Foot, Tony Harrison.

This report documents the key organisations involved in the quality assurance system i.e. those organisations and structures external to care providers and traces the development of quality assurance in the NHS in England since the Labour government’s “A first class Service: quality at the heart of the NHS” in 1997. It identifies the shifts which have occurred following the Health and Social Care Act 2012.

The Care Quality Commission is the successor to the Healthcare Commission (formerly the Commission for Health Improvement). It is responsible for licensing all providers of health and social care against essential standards based on self-declaration of compliance. It checks compliance using data and routine and unannounced visits. Focuses on outcomes of care achieved whereas CHI focussed on internal processes for assuring clinical quality standards.

The National Institute for Health and Clinical Excellence was set up to appraise new technologies and to produce clinical guidelines. It has recently been charged with defining quality standards for the treatment of a wide range of conditions.

The Council for Healthcare Regulatory Excellence now Professional Standards Authority for Health and Social Care is responsible for overseeing all the professional regulators.

The General Medical Council is responsible for registering doctors when they enter the profession, for making arrangements for dealing with poorly performing doctors, and, currently, for introducing a five-yearly system of revalidation.

The Nursing and Midwifery Council is responsible for registering nurses and midwives when they enter the profession and for dealing with poorly performing nurses and midwives.
Monitor is currently the regulator of foundation trusts. SHAs managed NHS Trusts. Following the Act it will become the economic regulator of all providers of NHS services.

The National Patient Safety Agency works to improve patient safety in NHS providers but has no powers of intervention. It is being abolished and some of its functions taken over by the NHS Commissioning Board.

The National Quality Board was established in 2009 to champion quality and ensure alignment of quality throughout the NHS but organisational responsibilities have changed since then.

These bodies use a wide range of approaches including licencing, standard setting, monitoring, performance management against national targets and now financial incentives. A study in 2008 concluded that England had the most extensive top- down quality assurance system in Europe. However, the goal of accountability and patient engagement, and establishing a blame free culture was not achieved.

The report’s authors conclude that the current system is complex and lacking in coherence with players having overlapping roles and responsibilities.

Principles which should guide re-design of the system are set out:

1 Patient centred - with regulators themselves focused on patients and users.

2 Engage staff. Encourage them to raise concerns and protect whistleblowers.

3 Support good governance and effective

leadership. Leaders and boards should recognise their responsibility for internal governance of quality, monitor the quality of care, take action to resolve issues, and create a culture of openness that supports staff to identify and solve problems.

4 Clarify roles of external organisations so they do not overlap or interfere with each other. They should be aligned with the activities of those delivering care.

Operational requirements are also defined:

1 Action should be taken when problems are identified but the gap in the present system may be perpetuated due to lack of funding.

2 Create a learning system- difficult if there is no organisational stability.

3 Subject standards to regular review which need to be dynamic, up to date.

4 Should take account of different levels of risk so be more cost effective.

5 Responsive to different settings including primary care.

This analysis and the recommendations are comprehensive and sound. However the report's conclusions are inconsistent and somewhat benign. The authors fear that "there is a risk that the response will focus on national regulators and will single out particular organisations for attention. As recent events in financial markets have shown, not all major risks can be foreseen..." Of course major risks could and should have been identified. The failures of these regulatory bodies were in fact included in the body of this report – the poor response to inquiry reports, scrapping the CQC's "dedicated whistle blower line", lack of focus on the patient etc. It is quite appropriate therefore that they take a major share of the blame. Are the current bodies better placed to prevent or deal with quality issues? Will changes be recommended and will Hunt respond?

On the other hand, it is difficult to excuse frontline staff- which this report does with the comment that at present "There is evidence that the environments in which staff work often depersonalise and dehumanise care-giving." As clinical lead in a laboratory I was sometimes amazed to observe the degree of commitment shown by staff - even though we were once removed from the patient so to speak. Chronic poor staffing levels meant that senior staff would work unpaid overtime and part time staff had to be persuaded to get away when their shift ended. Telephone manners were impeccable during the busiest of times. It was what the chief Laboratory Officer expected – and if I stayed in as long as they did and offered to act as telephone receptionist it signalled my appreciation of their commitment. In "My Plan to save the NHS" David Owen highlights this important concept which is danger of being overlooked: "The NHS is, in essence, a vocational service. It needs to retain within it a generosity of purpose, philosophical commitment and a one-on-one relationship with the individual patients." The failure of frontline staff at the Mid Staffordshire Trust could have been prevented by clinical leads or at least identified/acknowledged and presented to the board. The comment "There is a risk that the regulatory requirements of external bodies crowd out a focus on the effectiveness of internal quality governance arrangements…" seems to provide a get-out clause for trust boards and clinical managers. There is no call here for the introduction of statutory measures which will ensure that trusts establish a culture of caring and support for whistleblowers.

MALILA NOONE
Microbiology

Royal College of Physicians

Fellows of the College will be aware that there is an election underway for the role of President.

It is of interest that both candidates are members of NHSCA!

We can do no more than urge Fellows to read the candidates' statements and then use their votes.

The Public Accountability of Foundation Hospitals. Good Intentions or Evil Designs?

The Fledgling NHS
Before the NHS came into being, healthcare was largely speaking delivered according to the wishes and investment of the local community. Between 1946 and 1948 the medical profession as a whole vigorously opposed the Bill and only succumbed when offered mouth-watering financial rewards. With the enactment of the Bill, local involvement was replaced by a one size fits all service controlled by a centralised bureaucracy. Deprived areas in Britain benefitted. Affluent areas were handicapped. This massive takeover allowed the Treasury to sell off "redundant" infrastructure, misappropriate trust funds and dictate the parameters of the new system.

Affluent areas found themselves deprived of the generosity of the wealthy local entrepreneurs who had previously kept them ahead of the game. Now they had to wait in a long queue for necessary enhancements to their infrastructure and human resources, whilst deprived areas were lavishly refurbished and gifted droves of medical and nursing personnel.

All this was delivered at a time of severe national austerity.

Time passed
Over the past seven decades the mould has changed. Successive political initiatives have tried to wrest the last vestiges of medical involvement from the increasingly politicised healthcare agenda by buying off our consciences with tempting financial enhancements. Local public involvement withered. Now, we are left with a few stalwarts of social justice who can only voice their dissent by protest. Those who try to dominate the scrum with clinical expertise are penalised, only for the unerring, unhampered boot of the bureaucrat to score. Clinically driven tries score no points whilst financially driven penalty conversions win the match.

The New Mantra
The notorious NHS Bill, enacted in April 2012, has become the biggest politically motivated healthcare disorganisation of all time. We are now faced with a distorted mirror image of the healthcare landscape that pertained before 1948.

Solvent hospitals are being converted into profit making institutions (Foundation Hospital Trusts - FHTs) whilst their poor relations will close or be sold at knockdown prices. GPs will shortly be given the responsibility for balancing the community budget (Clinical Commissioning Groups - CCGs) and CCGs that fail will be axed.

The Poisoned Chalice
The Foundation Hospital Trusts (FHTs) were set up with two essential conditions before authorisation could be granted:

1. Financial solvency
2. Engagement with their clientele – the public

However in just a few years many FHTs have evolved opportunistically into self-governing, self-regulating monsters.

Moral accountability was addressed by allowing a FHT to recruit their public members from a unique locality, and then for that membership to elect, from their ranks, Governors who would hold the FHT Board of Management to account. However the boundaries of that unique locality, from which that public membership could be recruited, can be set by the FHT Board and may ultimately lead to the Council of Governors not being representative of the local population. Furthermore, the Chief Executive and Chairman and many of the members of the Board of Management do not have to reside within the local community. In this respect the mechanism devised to remove top down management has in effect inserted a remote group of individuals controlling a local enterprise. Basically that is little different from having decisions about local healthcare being made straight from Whitehall.

I am sure there must be some FHTs that have

interpreted the rules of engagement in the best interests of the healthcare of the local residents, but there are undoubtedly others that have bent the weakly constructed legislation to do their own thing. The minor titillations introduced in April 2012 by the Health and Social Care Act will not change the way in which opportunistic FHTs operate. My experience has been garnered during a brief period as a Governor at Colchester Hospital University Foundation Trust (CHUFT).

Engaging with the public

For FHT Public Governors to make a difference to the way in which healthcare is delivered to their local community, they need to maintain active contacts with the public that elected them, and then represent their electorate, with both a voice and teeth, in the hospital's decision making committees.

When CHUFT received authorisation in 2008 they had a vigorous campaign to recruit new members and set up local meetings at which a CHUFT employee would give a talk on a particular medical subject. These were essentially educational outings at which members of the public could ask questions about the particular presentation. These were not meetings at which members of the public could engage with their Governor representatives.

Members of the public could in theory contact their elected representative via the hospital's website. However, it was not until November 2012 that this deception was revealed. A number of Governors who had been in office for > 5 years were asked how many contacts with their electorate had been made by this means. The answer was, none! Then a member of the public sent a test email to a named Governor via the website.

The message was not passed on to the Governor. After two weeks a CHUFT employee sent an email to the correspondent asking her if she still wished to discuss her problem. I had already been dismissed as a Governor for contravening their Code of Governance. Therefore I went to the next "public" meeting of the Governors Council, as a member of the public, with the intention of asking the Chair to explain CHUFT's deception. She refused to let me speak! I sent a letter to the local paper and CHUFT responded with a denial of any wrongdoing!

I can only conclude that CHUFT never had any intention of engaging with the public or allowing the public free access to their elected Governors. It was far simpler to bypass the Governors and engage with the public whenever the FHT felt there was a need to show some commitment, but essentially just to advertise their current services and plaudits.

Setting the Governors' Agenda

With Council meetings only occurring on a quarterly basis the items on that agenda needed to be carefully and thoughtfully selected. In the normal course of events one might expect the Governors to identify topics for discussion and just leave the secretariat to decide whether the issues to be discussed should be in public or at a private part of the meeting.

At CHUFT an agenda setting session was usually held a week or two before each quarterly Council meeting. Typically less than 50%, often only a handful, of the Governors attended. It was then left to the Chairman to formulate the actual agenda of the next Council meeting. As a result the final agenda was decided by management and more often than not items raised at the agenda setting sessions did not find their way onto that definitive agenda. This meant that pressing issues could be delayed for up to six months before they underwent any discussion by the Governors. This enabled management to make final decisions on planning issues before the Governors had the opportunity to examine the rationale for management's actions.

Involvement in decision making processes

Some of the decisions that needed to be made by the hospital board required an element of public engagement lest the board be accused of ignoring the impact that their decisions might have on the community. Here was the ideal setting in which to involve the Governors. These people had been elected by the very public who would ultimately be affected by managerial decisions. But hospital managers had grown accustomed to carrying out their own patient surveys and did not need a bunch of superfluous Governors doing the job for them.

For CHUFT this really was a bridge too far. When this was discussed at a Governors Council Workshop (held in private after a routine quarterly meeting) members of the board argued that if Governors were involved with the committees that formulated the hospital's plans, then they would be unable to hold the hospital to account if the planned action went "tits up". Sadly this false logic prevailed and at a stroke CHUFT had succeeded in distancing Governors from the planning process. Two Governors had many years of work experience at the hospital and could have been a source of useful input.

One of the hospital's long-term problems revolved around the management of emergencies. The Board set up a special meeting in our Postgraduate Centre to discuss the issues and invited a number of national "experts" to attend along with a large number of medical staff. The senior consultant from our Emergency Assessment Unit asked me to attend. However, when the Chief Executive saw me there he politely told me to "clear off", because it was a "private" meeting and did not concern the Governors!

Active suppression of dissent

You might be surprised to discover that almost all the public Governors at CHUFT lacked the guts to complain about what was going on, but this was because the Chairman's interpretation of the Code of Governance meant that dissent was tantamount to contravening those rules of engagement. There were two particular taboos.

1. Governors were forbidden to discuss their concerns about issues on the agenda outside the confines of official Governors Council Meetings.

2. Governors were not allowed to contact CHUFT staff except via the secretariat.

The former meant that the Chairman had direct control of the Governors. The latter enabled her to keep her beady eyes on what Governors were thinking and where necessary nip dissent in the bud.

In order to help her in these matters she had a "Lead Governor" who was voted for by < 30% of the Governors. No one saw this role as important but equally no one realised that this person (with a professional background in IT) would very quickly become joined at the hip with the Chairman.

Monitor

Monitor's prime function is to ensure the FHT's financial solvency. Clinical issues may be raised with Monitor, but these would not normally lead to loss of authorisation. Monitor is not interested in breaches of the Nolan Principles of public life.

The Foundation Trust Governors Association (FTGA)

The FTGA is a body run by Capita and funded by contributions from FHTs. It organises quarterly workshops to facilitate the effectiveness of Governors. Every FHT can send a few delegates to these gatherings, but for most FHTs it would take up to three years for all the Governors to attend just one meeting. These meetings are in effect an all-expenses-paid jolly! Governors do not automatically become members of the FTGA but are encouraged to join.

Redress

In theory Governors can dismiss the Chairman and Non-Executive Directors but, when the Chairman and Lead Governor are in cahoots, this becomes almost impossible. The Colchester Council of Governors did succeed in sacking their first Chairman but his successor was much more savvy.

Governors can be dismissed, but only by a majority vote of their fellow Governors. However, it is likely that in most cases dismissal is orchestrated by Management. If you irritate that managerial beast you are likely to have your card marked. The Chairman plays a pivotal role in collecting and massaging the "evidence" before it is presented to the Governors Council.

In my case it was my "flagrant" flouting of the Code of Governance that would be used to convict me. In order to get that necessary evidence, some of my emails to colleagues and fellow Governors mysteriously found their way to the Chairman. She vigorously denied any email hacking activity and claimed she had no knowledge of how

the information had come into her hands. This prompted a special private meeting, in my absence, to formulate the charge and decide my fate.

Since the charge ignored the clinical appropriateness of my correspondence, I sent a complaint about our Chairman to Monitor. This added fuel to the Chairman's determination to get rid of me. I also informed the FTGA of what was going on.

Monitor was not really interested but, after many weeks, replied just to say that they had noted the contents of my letter.

The FTGA Committee members expressed considerable concern although, following my dismissal, they lost all interest in the case.

IS THERE A WAY FORWARD?

We could insist that the legislation legitimising FHTs should be repealed, but that would lead to yet another upheaval. Alternatively, if the perverse legislation underpinning the role of Governors were changed, that would make a major difference. Their current erectile dysfunction has to be cured. Symptomatic treatment with a bit of Political Viagra will not suffice. The Chairman needs to encourage intercourse between the Board and the Governors and stop acting as the ultimate contraceptive.

The Electorate

If the FHT is there primarily to serve the local population then the boundaries of the electoral ward should be set by the catchment population of the local GPs. That would have been the territory funded by the local PCT. In future that will be the area of authorisation of the new CCG. In this way Governors elected by this more precisely defined local population would truly represent local healthcare desires and aspirations. These boundaries might be more difficult to define in a large metropolis.

The Allegiance of Governors

Governors are elected by the local population and the primary allegiance of a Governor must be to that electorate. The current Code of Governance has to be changed and the repeated references, that a Governor's duty is to act as the FHT's best buddy, should be erased.

Basic Knowledge

If the Governors' Council is going to have real credibility then half of its public members should have worked at the local hospital. Ideally these would be retired medical and nursing staff. In my experience, lack of medical knowledge severely handicapped the decision making potential of almost all the Governors, even though they had come with the best of humanitarian intentions.

The Chairman

We need to break the poisoned link between the Council of Governors and the Trust Board. Public Governors need to be able to elect their own Chairman from among their own elected ranks. In that way the Governors' Chairman would be able to set their agenda, encourage discussion and set up ad hoc meetings whenever the need arose.

Access to Information

The Governors' Council should have unfettered access to information and members of staff, and be able to summon members of the Board to explain their actions in public. Confidential information while contracts are being negotiated would be excluded, at least until after these had been signed and sealed.

Access by Governors to hospital departments should in future be arranged through the heads of departments and not by the Governors' secretariat, which in turn is under the thumb of the Board.

Conclusion

Maybe I am being a bit overambitious, but if successive governments really meant to involve the electorate in the provision of healthcare, then they need to put their money where their mouth is. *No decisions about me without me*, currently rings rather hollow. Doctors need to take back their squandered role in medical decision making. You have to get involved from the *inside*. Lobbing projectiles over the wall into Management's stronghold is a waste of time and effort.

MARK AITKEN
General Medicine

Political Activity

Our political activity seeks to influence events, either by direct approaches to politicians, sometimes as part of a joint venture, or indirectly by influencing public opinion recognizing that politicians appear most receptive to those who put them in power, particularly as elections approach.

Recent actions have involved both pathways.

Some members will have received a personal email invitation from Andy Burnham, Shadow Health Secretary to respond to his consultation. We took the opportunity to request a meeting :-

Dear Mr Burnham

Members of our organization have received personal invitations to comment on your paper "21st Century NHS and social care, delivering Integration" and many will no doubt do so as individuals.

As an organization, we entirely agree that there should be a change of direction away from fragmentation towards greater integration of the three elements of care. One area of particular concern to us is the divide which has developed and with recent policies is deepening, between Primary Care and the Hospital Service. This not only affects the management of both physical and mental health problems but also makes more difficult effective cooperation with Social Care.

As you will be aware, the main barrier is the Purchaser/ Provider split, fundamental to the market system. The part that concentration of attention on running a competitive market may have played in the Mid Staffs saga is a further indication of the need for an urgent rethink on its place in health care.

We support the widely expressed view that what the NHS does not need is another top- down reorganization of the type it has suffered frequently in recent decades , which have done so much to lower morale and damage the ethos of public service. However it should be possible to work towards our goals in an incremental, non-disruptive manner whilst keeping the ultimate objective firmly in view.

We would very much appreciate the opportunity to meet you for discussion of practical steps that could be taken.

The letter was sent on 11th February but no response has yet been received

A great deal of activity has taken place around the secondary legislation arising from the eventual passage of the Health & Social Care Act 2012, particularly Section 75.

A parliamentary briefing was prepared for KONP, explaining the critical nature of this and urgent need for action. The key parts of this are reproduced below. The full document with references is available on request.

Members have been asked to take part in a series of actions to try to ensure that Section 75 does not pass unchallenged and many report having done so.

Firstly, to write to the Lords Secondary Legislation Scrutiny Committee stressing the need to ensure careful examination and debate.

Secondly, to sign a 38 Degrees petition calling for the same.

Thirdly, to add their names to an open letter to the press, organized by Dr David Wrigley, a member of BMA Council who works closely with our members there.

As we go to press, there are rumours that Jeremy Hunt is preparing to reconsider Section 75 but whether any change will be significant or cosmetic remains to be seen.

It would appear though that this multi-pronged attack has had some effect and it is good that our members have played a part in it. It is unfortunate though that nearly half of them are denied the opportunity to do so because we do not have their email addresses.

We are engaged in a very tough struggle to try to preserve the sort of health system which the vast majority of people want and we need all the strength we can muster. **I make no apology therefore for again appealing to those other members to let us have their current email addresses. If you have NOT been in receipt of the above messages in late February this means YOU!** I can give assurance that we do not bombard you with unnecessary emails and that they come "blind copied" so that your Inbox is not filled with multiple names and addresses.

PETER FISHER

PARLIAMENTARY BRIEFING – 21 FEBRUARY 2013
Privatising the NHS through the back door

- On 13th February 2013 the Government published the regulations (SI257) under Section 75 of the NHS and Health Care Act 2012[1]
- Assurances were given by ministers during the passage of the Bill through Parliament that it did not mean the privatisation of the NHS, that local people would have the final say in who provided their NHS.
- The regulations just published break these promises by creating requirements for virtually all commissioning done by the National Commissioning Board (NCB) and Clinical Commissioning Groups (CCGs) to be carried out through competitive markets, which will have the effect of forcing through privatisation regardless of the will of local people. They contain legal powers for Monitor to enforce the privatisation spontaneously or at the request of private companies that lost bids.
- They would also make it impossible to fulfil some of the key thrust of the Francis report recommendations.

What did ministers say then?

- Andrew Lansley MP: "There is absolutely nothing in the Bill that promotes or permits the transfer of NHS activities to the private sector." (13/3/12, Hansard[2])
- Andrew Lansley MP, 12.02.12, letter to Clinical Commissioning Groups: "I know many of you have read that you will be forced to fragment services, or put them out to tender. This is absolutely not the case. It is a fundamental principle of the Bill that you as commissioners, not the Secretary of State and not regulators – should decide when and how competition should be used to serve your patients interests.."
- Simon Burns MP: "...it will be for commissioners to decide which services to tender…to avoid any doubt—it is not the Government's intention that under clause 67 [now 75] that regulations would impose compulsory competitive tendering requirements on commissioners, or for Monitor to have powers to impose such requirements." (12/7/11, Hansard, c442[3])
- Lord Howe: "Clinicians will be free to commission services in the way they consider best. We intend to make it clear that commissioners will have a full range of options and that they will be under no legal obligation to create new markets…." (6/3/12, Hansard[4])

What do the regulations say?

According to David Lock QC, the regulations as a whole have the effect of closing down the current option of an in-house commissioning process, even if local people wish it. This option has been taken in a number of cases, including *since* the passage of the Act[5]. Ministers have confirmed that at the *present* time such arrangements are legal and would not give rise to challenge under EU Procurement law[6].

These regulations sweep all existing arrangements between NHS bodies, and just about all commissioning done by the CCGs, into a market framework[7] - and thus into the remit of EU competition law. Once this is triggered, private providers gain rights which make halting their encroachment financially – and thus politically – virtually impossible.

Regulation 5 - awarding a contract without competition can, effectively, only° be done in an 'emergency', a much narrower restriction than suggested in the parliamentary debate.

Regulation 10 makes whatever Monitor judges to be an "unnecessary" restriction of competition, illegal. It thus effectively closes down the current option of one state body (i.e. the NHS Commissioning Board or a Clinical Commissioning Group) merely making a new arrangement (not contract) with another – i.e. an NHS Trust.

Regulation 12 forces commissioners to use the market to meet waiting time considerations, in contravention of assurances offered to CCGs during the passage of the Act when they were told they would have discretion and could also consider quality issues. This regulation also ignores the summary of the DH's own consultation which highlighted that waiting time considerations should not be used to override quality considerations.

Part 3 Regulations 13-17, covering Monitor's powers

The sweeping (and time unlimited) statutory powers given to Monitor enable it to decide when the CCG has breached regulations (Regulation 14), to end any arrangements the CCG has come to and to impose their own (Regulation 15) – including the criteria governing selection of suppliers, and more fundamentally, the decision about whether to use competitive methods like tendering and AQP at all. Under these regulations Monitor will have sweeping statutory power to enforce (as yet unseen) guidance, whereas the current guidance is not legally binding.

The AGM and Conference 2013

will be held on Saturday 5th October at

Bedern Hall, York

Elsewhere in this Newsletter is a report by Morris Bernadt on the Lewisham Hospital march and the Editorial refers to John Lister's detailed report and analysis, part funded by NHSCA, on the Draft Plan for SE London.

This report is available electronically to our members on request to NHSCA

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