NHSCA

EDITORIAL March 2011

Interdependence and Autonomy in the NHS - A Market Conundrum

This issue of the NHSCA Newsletter has been themed on the general concept of how a variety of specialist/consultant medical practitioners see their specialism taking its place in a well integrated health care system. The general principle of integration of health and social care services extends into the very many life and work customs and activities which bear on human health and disease. Each of the contributions to the Newsletter is necessarily brief and constitutes the personal reflections of the contributor. They cover only a small part of the great number of specialised activities which now go to make up a comprehensive medical service. They have been written by individuals who are very aware of the opportunities and limitations of the current structure of the health care and social services and with some regard to the new pressures applied to them by past and portending market reforms. It would be of interest to seek the response of the patient-public to the thoughts and ideas expressed.

Broadening Frontiers of Medicine

The dream in 1948 was of a fully integrated National Health Service, aiming for healthy individuals within healthy populations in which care in the community, eventually to be delivered through a network of Health Centres, was linked in a continuum of care with specialised services provided largely in refashioned hospitals. The long period of public discussion and debate which preceded the landmark 1946 National Health Service Act broadened the concept of health care from the paradigm of the hospital ward, filled with patients with advanced disease, into the large communities of working people and their families where so many of these devastating clinical disorders were incubated.

Classical public health, having largely conquered the contagions, was finding common ground with the relatively new discipline of clinical epidemiology which was increasingly concerning itself with the non-communicable diseases. This set the scene for important new concepts relating the health of individuals to the health of the societies in which they lived. In his momentous paper "Sick Individuals and Sick Populations" Geoffrey Rose demonstrated clearly that the largest numbers of disease victims – numerically the major social burden of the disease – arose from people with only minor elevations of risk factors, at low individual risk but of whom there were great numbers. Medicine traditionally concerned itself with patients with major risk factors for the disease, at very high individual risk but contributing little to the total population toll.

Integrating the New: Public Health

The consequence of these observations was that while identification and treatment of those at high risk, i.e. the high risk strategy and the business of clinical medicine, was of great importance for this small number, it did relatively little to lessen the total social burden of disease. A substantial reduction of this burden required a strategy which called for significant modifications of habit and way of life throughout the population. This recognition introduced new dimension into the interaction between medicine and society.
The application of these principles in prevention and treatment of coronary heart disease was demonstrated by Pekka Puska in the North Karelia province of Finland. A determined intervention into the nutritional, physical activity and tobacco smoking behaviour of the population was rewarded by an 80% fall in the rates of coronary heart disease, dramatically

greater than the fall in the rest of the country. It is highly likely that the greatly improved outlook for coronary heart risk, particularly in younger people in many westernised countries has been effected by such well coordinated, population based measures.

Primary and Hospital Care; the GP and the Consultant.

The sharp divide between the general practitioner and the hospital consultant has historical origins, now almost irrelevant, but still influencing the relationship and inflicting a damaging division upon the profession. In the 19th and much of the 20th century, the consultant was seen as the aristocrat of the profession who regarded his GP brethren as the lower orders, a contempt which he kept carefully cloaked since consultant practice depended on referrals from below. The workplace of the GP was often a converted drawing room in a respectable house but sometimes, in the city centre, a lock-up shop-front in a down at heel street. The consultant lorded it often as an unpaid honorary, in some noble old Victorian pile or among the soot-stained stones of the great teaching hospital but with consulting rooms in some select quarter of town. Their reward, apart from the glory reflected from the brand of the famous teaching hospital, was the privilege of instructing medical students who would ultimately be the source of paying referrals.

GP Purchasers (Commissioners) and Consultant Providers – the Transactional Divide

These old roles and attitudes which conditioned generations of professionals have largely dissipated but the division remains. Even a new and advanced generation of GPs took (as some probably still do) a grim pleasure in the 'dethronement' of the hospital consultants and a certain reversal of roles which followed the establishment of the market NHS more than 20 years ago. Division still scars the relationship between primary care and hospital practice and has lent itself to skilful political exploitation. Consultants and GPs have been deliberately separated into a transactional posture across a pseudo-market gulf between 'purchaser' and 'provider'. The most recent act of placing 80% or so of the NHS spend in the hands of the GPs carries little more than an airy acknowledgement that consultants might just have some say in the disposition of these resources. It is difficult to escape the conclusion that this is an example of a 'divide and conquer' strategy of a manipulative government.

It is reassuring that, in an attempt to forestall the increasing separation of primary and secondary care by the Lansley Act, the Royal College of Physicians has recommended hospital consultants to meet with the GP colleagues who will, nominally, be commissioning them. Together, on a colleague to colleague basis they could try to work out the most clinically and professionally desirable ways of remodelling their relationships and hopefully frustrating the transactional Chinese Wall which currently separates them and which renders both sides more manipulable by market management. How secure these meetings between consultants and GPs will be from accusations to the Cooperation and Competition Committee that they unfairly favour the NHS as against the private provider remains to be seen. Doctors in a Lansley future may have to tread much more carefully in professional relationships which turn out to be malpractices that they never imagined might breach competition law. It may not only be the entrepreneurial private commissioning companies that are readying themselves for action but a whole new set of opportunities may be opening up for enterprising law firms.

Teaching, Training and Research - Orphans of the Market

Proposed legislation from the impatient Lansley reformers shows a lack of real concern for the vitally important areas of medical education, professional training and clinical research. The dissolution of the long-established and fruitful cohabitation of clinical and academic medicine within the NHS operating successfully, on the basis of an informal 'knock-for-knock' formula was an early casualty of the financial stringencies of the internal market. Subsequent reluctance of management to allocate more time and resource outside income-generating items of clinical service has not fully succeeded in re-establishing the lively academic life of heretofore.

Continued Professional Development – postgraduate education and the like – depends upon the collaborative working of a variety

of locality clinical units and the Postgraduate Medical Deaneries of their areas. The abolition of the Postgraduate Deaneries as proposed in a recent White Paper 'Developing the Healthcare Workforce', linked to the Lansley NHS market reforms and this has raised concerns with the General Medical Council which has argued that local spokespersons with special concern for medical education should be appointed to ensure that market-driven changes are not allowed to override the needs for education and training. Also on the agenda is a potential new demand for remediation resulting from revalidation failures. It is difficult to predict how large a new requirement this will be but it will need to be accommodated and coordinated with academic and training activity which will themselves be bedding into the new, competitive clinical care systems.

Integration or Collusion – New Regulatory Proprieties

Just how long will it be before the Market Monitor or the Competition Controller makes an example of some interprofessional referral which transgresses the rules of the market? Will doctors in an expanded market future have to consider risking some legal misinterpretation of a quick clinical arrangement which cuts regulatory corners in the patient's interests? Sticking to the regulatory market rules already hinders easy communication between health care professionals. No longer can hospital consultants refer outpatients to each other without first returning the patient to the GP for a new (money-bearing) referral. And even that referral may be diverted elsewhere or even blocked by the system of Referral Gateways which will censor and if necessary redirect GP referrals to make for a more cost-effective appointments system! Are we entering a world where what might have been welcomed as a patient-friendly collaboration between GP and consultant – between the community-based primary care team and the hospital/university-based specialist unit, opening up new possibilities for improving integrated patient care is turned by the rules of the marketplace into a relationship that is suspect as a potentially fraudulent collusion or conspiracy. Here is another little recognised potential erosion of the patient's confident assumption that any arrangement between doctors was exclusively in their own personal clinical interest.

Health and Social Care Coordination

A well coordinated working relationship between health care and social care has been the subject of discussion and dissension probably since the dissolution of the monasteries (which in their own unquestioning way looked after both the sick and the poor). Despite the clearest of links between social conditions and the genesis, treatment and outcomes of ill health and disability, the problems of the division of resources between them remain contentious; should they draw on a single funding source, basing allocation on a flexible local appraisal of priorities or should each be provided with its own ring-fenced resource allocation with a hard, agreed and inescapably arbitrary line drawn between what is clinical and what is social? Government proposes to solve this dilemma by creating a new independent agency. A new core public health service, Public Health England, which "will integrate public health expertise, providing national support and advice, for local delivery". It proposes to join up "…the local work done by the NHS, social care, housing, environmental health, transport and leisure services……focussing on public health at a local level…. a strategy to improve the health and wellbeing of the nation, and address the issues of health inequalities".

The demand for sound collaborative planning in this field is likely to balloon in size over the next decades as the population continues to age with a predictable growth in physical and mental disability and the consequent requirements for support in the home. A well supported, locally sensitive, publically accountable, flexible Social Care Service could enormously enhance the quality of life of large numbers of elderly and/or disabled citizens. It is questionable however, with the stringent restriction of funding judged to be necessary in the present national financial state as to whether the generous funding required for the effective launching of such a service will be available. Doubtless government with its roseate view of the Big Society, anticipates the generous and sustained supply of voluntary workers to flesh out this service. Whether this vital collaboration can be made to work in the competitive commercial climate of NHS plc remains to be seen.

HARRY KEEN
Guest Editor

Political Activity

There has been a lot going on, stimulated of course by the White Paper, now a Bill going through Parliament and at the Committee stage. Although this is meant to be a time of detailed scrutiny it is clear from statements by politicians of all parties that it is very much under the control of the Whips.

Dr Sarah Wollaston, newly elected Conservative MP who as a former GP in South Devon would have liked to be on the Committee, withdrew when it was made plain to her that it would be at the price of total acceptance of the Bill in all its clauses and that critical amendments would not be accepted. Any such amendments put forward by Opposition members can be voted down as there is a Coalition majority.

Meetings

David Halpin, one of our West Country members, has approached Dr Wollaston for a meeting with NHSCA representatives, she has agreed and we await suggested dates.

Meetings have already been held with Stephen Dorrell MP, chair of the Health Select Committee and former Secretary of State for Health and with Diane Abbott MP, Shadow Minister for Public Health, Reports appear elsewhere in the Newsletter.

Letters

A letter which had been co-ordinated by NHSCA and KONP then sent to the press by the BMA, appeared in the Times of 15th December:

"As doctors we welcome the news that the Prime Minister has asked Oliver Letwin to review Andrew Lansley's White paper on health, Equity and Excellence: Liberating the NHS. Rather than "liberating the NHS", these proposals seem to be an exercise in liberating the NHS's £100 billion budget to commercial enterprises. We believe they will destroy the NHS as we know it.

The last thing the NHS needs at this time of austerity is another reorganization, (costing up to £3bn according to the Kings Fund), damaging morale and the ability to make decisions about NHS economies based on rational planning rather than market forces.

Andrew Lansley's aims of putting patients at the heart of care, involving clinicians in decisions about the provision of services and reducing managerial costs could be achieved without the massive structural upheavals of abolishing PCTs and SHAs. PCT Boards could be restructured, to give much better representation of clinicians, members of the public and accountable members of Local Government. The present, costly healthcare 'market' could be abolished, saving billions in transaction costs and achieving the £20 billion 'efficiency savings' demanded by Sir David Nicholson.

BMA policy is to uphold the founding principles of the NHS (which are held dear by British citizens) that health care should be on the basis of public provision not private ownership, co-operation not competition, integration not fragmentation and public service not private profits. 4 out of 5 doctors believe the reforms will not benefit patients.

The recent Commonwealth Fund (Mass) report found that only 3% of British people thought their health service needed radical restructuring, the lowest proportion of any country studied. With health professionals and the concerned public so opposed to these reforms, it would surely be stubborn folly for the government to impose them."

There were over 226 signatories, including Hamish Meldrum on behalf of the BMA. Many more came in too late for inclusion.

A second letter organized by NHSCA/KONP appeared in the Times on 18th January to coincide with the publication of the Health and Social Care Bill.

"As doctors we believe the Health Bill represents an irreversible step towards the dismantling and privatisation of large parts of the NHS. The Health Secretary is already implementing its proposals even though the Bill is not yet law. MPs and Peers must use this opportunity to avert a disastrous experiment with the nation's healthcare.

The great majority of doctors - GPs as well as hospital doctors – oppose it. So do leading experts in the King's Fund, the Universities and very many significant organisations including the Royal College of Nursing and the Community Practitioners and Health Visitors' Association, the NHS Confederation, the Patients Association, and the trade unions with many NHS members, Unison and Unite.

The wholesale re-engineering of the NHS and the destruction of Primary Care Trusts is very expensive and totally unnecessary. If the goal is to involve GPs in commissioning it should be noted that some GPs are already working successfully with PCTs. The Government's fulsome claims to be engaging GPs cannot conceal that this 'policy' is a cloak for hospital closures, mergers and privatisation.

The use of Monitor to compel commercial competition will make hospitals subject to EU competition law and threaten the end of an equitable service. There is much evidence that price competition in a market worsens health care and no evidence that it improves it.

There is no democratic mandate for the Bill – the policies received no mention in election manifestos or in the Coalition Agreement. We urge Parliament to reject this unnecessary Bill which does not reflect the enduring values of the NHS. These are cherished by the overwhelming majority of the population."

We collected over 400 signatures on that occasion

Another very important and influential initiative was the letter to the BMA leadership by NHSCA Co Chair Clive Peedell and 100 others.

"Open letter to the Chair of BMA Council, Chair of the BMA General Practitioners Committee (GPC), and all members of the BMA GPC

Dear Dr Meldrum, Dr Buckman and members of the BMA General Practitioners Committee (GPC)

Following the publication of the health White Paper earlier this year, Dr Meldrum wrote to the profession to let us know how the BMA was going to respond to the consultation process. As you know, BMA Council agreed only to "critical engagement with the consultation process".
The consultation period is now over and it is clear from the Department of Health's response to the consultation, that the BMA's policy of "critical engagement" has failed to persuade the Government to slow down or change its approach. The BMA quite rightly responded with a damning press statement:

"There is little evidence in this response that the government is genuinely prepared to engage with constructive criticism of its plans for the NHS. Most of the major concerns that doctors and many others have raised about the White Paper seem, for the most part, to have been disregarded."

In fact, Andrew Lansley's plans are now even more market based. Within the new Operational Framework for the NHS in England, he is introducing "price competition" into the NHS, which fundamentally changes the NHS from being a "quasi-market" system of fixed prices (tariffs) to a much more open market system. Hospitals will be allowed to charge rates lower than the national tariff, which sets the prices for thousands of NHS procedures and covers roughly half of hospital income. According to Zack Cooper from the London School of Economics, "Every shred of evidence suggests that price competition in healthcare makes things worse, not better."

The NHS Confederation also share this analysis : "Economic theory predicts that price competition is likely to lead to declining quality where (as in healthcare) quality is harder to observe than price. Evidence from price competition in the 1990s internal market and in cost-constrained markets in the US confirms this, with falling prices and reduced quality, particularly in harder-to-observe measures".
Moreover the BMA has stated that it has "concerns over the use of 'best practice' or deregulated tariffs in the NHS, as the system brings with it price competition, which can risk basing decisions on price rather than on clinical need".

The White Paper has not even been published as a Health Bill as yet. It will then need to be read in Parliament and then go through the legislative process. We are therefore very concerned that the BMA and more specifically the BMA General Practitioners Committee (GPC) is treating proposed policy (i.e a White Paper) as if it is policy. For example, on the 17th December 2010, the GPC Chair, Dr Buckman wrote a letter to all GPs stating that :

"Practices should now be working with other practices to make progress in setting up their embryonic consortia and electing and appointing a transitional leadership". In addition, the BMA recently published a briefing paper called "Shaping change: BMA's position on the future development of the proposed NHS reforms". On the topic of GP Consortia and commissioning, the paper stated that: "The pace of change in developing commissioning must allow the vanguard to develop swiftly".

So, despite explicit reassurances from Dr Meldrum and BMA Council that the BMA would only "critically engage" with the consultation, this does not appear to be in keeping with what the BMA is actually doing. The fact that market based policies have actually been strengthened by Mr Lansley, goes completely against the BMA's stated policy from numerous Annual Representative Meetings (ARMs). It is therefore clearly time for the BMA to withdraw its "critical engagement" policy with the coalition government and start to engage properly with the membership. It is remarkable that despite "the most radical restructuring of the NHS since its inception" , BMA Council recently voted against holding a Special Representative Meeting (SRM) of the BMA to allow its membership to debate the current proposals. This is in contrast with the BMA's stance against the other most significant NHS White paper reforms, Working for Patients in 1989, where two SRMs were held to debate the issues. Whilst the BMA has also failed to formally survey the profession on the White Paper, surveys conducted by the King's Fund and the Royal College of General Practitioners (RCGP) have both revealed major concerns from the profession, with fewer than one in four doctors believing that the proposed reforms will improve the quality the patient care provided by their organisation or practice.

We believe that the BMA and more specifically the BMA GPC currently has no mandate from the BMA membership to continue with the "critical engagement" policy that it is still clearly employing. Mr Lansley's reform agenda has been widely criticised across the health policy and political spectrum as moving too fast. These critics include one of the Coalition Government's own Cabinet minsters, Mr Vince Cable. Yet, the current approach from the BMA only serves to increase the pace of reform because the BMA has effectively sent a message to the profession that the White Paper is a "done deal".

We have serious concerns that the White Paper reforms will fundamentally undermine the founding principles of the NHS by creating a more much expensive and inequitable market based healthcare system. The "Curate's Egg" is a rotten egg. However, we also believe that it is not too late to save the NHS by derailing the White Paper reforms. The Health Service Journal placed Dr Meldrum at number 3 and Dr Buckman at number 8 of the top 100 most influential people in the NHS this year (up from number 35 last year) and stated:

"From an influence point of view the BMA is critical because it could derail the coalition's white paper reforms, which propose a clinically led system. If the BMA were to say no, then the whole initiative could grind to a halt".

Thus the NHS really is in your hands. We understand the great pressures you are under, but it is now time to mobilize the power of the profession and stop these damaging reforms which will destroy not only the NHS, but also profoundly impact upon the social fabric of our nation.

This is a great opportunity for the BMA to achieve redemption for its opposition to the inception of the NHS in 1948. We urge you to take it and will support you 100% of the way.

Yours Sincerely

Dr Clive Peedell
Consultant Clinical Oncologist
BMA Council
BMA Political Board
Co-chair NHS Consultants Association"

In addition to the 100 signatories, the letter after publication on the BMA website attracted 100 Rapid Responses, 98 of which were in agreement.

This, together with hard work by NHSCA members on the BMA Council and like minded Council colleagues must have been instrumental in the BMA finally acceding to the request to hold a Special Representative Meeting to reconsider its attitude to the Bill.

The meeting is being held on 15th March and a number of resolutions calling for outright opposition have been submitted by Divisions.

Initiatives like the above have only been possible through the ability to communicate rapidly with members by email.

Unfortunately, despite repeated requests, we still only have addresses for just over half our members. This reduces the impact we can make and of course deprives individual members of the opportunity to take part.

At this time when events are moving so rapidly and the stakes so high I make no apology for asking those who have not already done so to let us have an email address.

Finally, advance notice (or reminder because there has already been considerable publicity), of a major **March and Demonstration to be held in London on Saturday 26th March.**

NHSCA will be taking part, with our banner. The precise time and meeting point have yet to be determined but all will be notified by email (where available) and the information will also appear on the Association website.

PETER FISHER

Plot Against the NHS

Colin Leys and Stewart Player

What will Mr Lansley's new health care market mean for patients? Is there really no alternative? Do the coalition government's plans for the NHS really mean a big change of policy? Or do they just bring into the open what New Labour was already doing? This book shows what has really been going on:

The plot: For ten years a 'policy community' around the Department of Health has schemed to replace the NHS. They want a US-style health-care market coming in by the back door. Why tell us, or parliament?

The template: Listen to Kaiser Permanente - the US health insurance company. Expand its influence in the Department of Health. Make the American market the model.

The players: the insiders: the 'policy community', corporate heavies, management consultants, thinktankers, freelancers and hired hands, including some academics and doctors. They can use the 'revolving door': company envoys can get jobs in the Department of Health, and ex-ministers and officials can get well paid jobs in the private sector.

How? Make more openings for the private sector at every stage of 'reform'. Start 'pilot schemes' but don't evaluate them, have them 'rolled out' across the country. Buy off critics, or (if that fails) ridicule them. Terrorise the NHS workforce, divide and rule. Spin, Spin, SPIN

Who pays? Patients and doctors tell us: 'reforms' are driving up costs, services are being cut, and quality is falling – unless you can pay to go private. This is the shape of things to come.

Who profits? the private health industry takes over NHS hospitals, runs GPs practices: their interest, profit, will subordinate the public interest.

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will be held on Saturday 1st October

at Bedern Hall, York

What Should Our Public Health Service Look Like?

Historical Backcloth

In 1948, when the NHS was established, the three main parts of the medical profession (general practitioners, hospital consultants, and public health doctors) were kept apart in their own domains within a "tripartite" service (as it was known). For all its deficiencies, it provided some stability for successful practice for a quarter of century. However, since 1974, and in England, most doctors have become almost "punch-drunk" by almost continuous change (revolution?) in the manner in which the service is managed.

Public health doctors have suffered more than most during this period. In the later nineteenth and early twentieth century their predecessors had enjoyed a "golden age" of public health, when eradication of communicable diseases as the commonest cause of death, and improvements to maternal and child health, were major achievements. Subsequently, however, local authority-based public health lost its way as the major health challenges became chronic diseases and no longer communicable diseases, and these public health departments simply failed to rise to this new challenge.

The hope in 1974 was that "integration" with other parts of the NHS would provide a new beginning to what was now called (but only for a little more than a decade) community medicine, but in practice public health doctors became swamped within the hospital service, with much too close relationships to NHS management. When at last proper departments were established under the leadership of directors of public health, many NHS PCT chief executives diverted the attention of members of the staff of these departments towards working on chief executives` agendas, rather than on public health ones. Only the stronger directors of public health felt able to stand up to chief executives to prevent this. Now in England the world of both general practitioners and public health doctors is once again being turned upside down, with profound implications also for hospital doctors. Where might they all land? It seems that public health doctors are to return to local government.

Let`s pretend that we could all go back to a health service in which we were all allowed, rather than being forced at all times to compete, to work collaboratively so that together we could make the best of medical science and expertise available to public and patients, without thought or worry about profit or loss (it sounds almost like Utopia, doesn`t it?): Where in this ideal world should public health sit so as to be most effective, and what type of departments would be best positioned to take optimum advantage of this situation?

What constitutes an effective public health department?

An effective public health departments needs:

- The capacity to maintain proper surveillance of health threats and health needs in the local population;
- A team of health data analysts to interpret outputs of surveillance, etc., and to report accordingly;
- A team of consultants to take decisions and to lead appropriate interventions in subspecialty fields, such as health promotion (including disease prevention), health of the elderly, health of children, sexual health, environmental health, communicable disease control (these last two are currently carried out in England by the Health Protection Agency, shortly to be abolished);
- An effective and well-trained team of health promotion officers;
- A director of public health with leadership qualities, to coordinate all of these other staff;
- An effective public health laboratory service, currently located in certain hospitals.

One of the principal responsibilities of the consultant staff of each such department will be to provide independent public health advice, based on scientific assessment of local needs, on the requirements of many services relevant to the health of the local population. Many of these services will be provided by other parts of the NHS, some others by local authorities, a few perhaps by charitable bodies, NGOs, etc. The point is that such consultant opinion should be available as required by all agencies likely to benefit from it, without fear, favour, or prejudice. Moreover, each director of public health should publish an annual report on the state of health locally, highlighting particular health problems which need to be addressed.

Where should public health departments be based?

These functions have not always been properly carried out by public health departments based in PCTs; usually, far too much time has been allocated to consideration of NHS services, to the effective denial of adequate time being allocated to meet the needs of other organisations. But might not an equivalent situation develop very rapidly if public health departments become based in local government? Will not the local government agenda become enforced as that one deemed to have at all times top priority?

It is not often that we look to the Baltic States for exemplar services that we may wish to imitate. However, in Lithuania, most public health departments are funded quite separately from both primary care and hospital services – they are funded centrally, direct from the Health Ministry in Vilnius. This model has considerable attractions, provided the separate funding stream, adequate to provide a full public health service, is guaranteed. Based in another organisation within which public health objectives will take second place, most public health departments will be "blown off course", with their priorities being influenced by those of the host. But public health opinions, recommendations, and priorities should be objective, unbiased and independent, and a separate funding stream to support public health departments could help to ensure that this would be the case.

This is not to suggest that, for public health physicians, close working relationships with hospital consultants and with GPs (and their other colleagues in primary care) are not incredibly important, and several types of services (e.g. screening) depend for their effective functioning on the maintenance of such close relationships. Although part of an independent service, public health physicians should regularly meet with and mix with their medical colleagues in other services, e.g. in postgraduate centre meetings, etc. For an effective public health service, departments need to be large enough to have critical mass, and a larger number of smaller departments might prove to be very ineffective. So departments should serve populations of around 300,000 to 500,000, broadly speaking arranged to match one or two district general hospital catchment areas, with their populations defined as according to appropriate local authority boundaries, as collaboration with local authority colleagues and services is also most important for effective public health.

The health advocacy function – 'vertical integration'

Public health priorities should always be driven by determinants of the health of local populations as those which must be addressed by public health services. In 1948, when the NHS was established,

most of the major determinants of health were determined locally (food was grown around market towns, employment was locally controlled, without multinational firms, etc., education was determined locally,…..etc.). In 2011, the world is very different! In 1997 a study concluded that only 20% of decisions affecting the major health determinants are taken at UK level or below (this 20% includes all NHS services), while 30% were taken in the context of the hitherto uncontrollable global economy. 50% were thought to be taken at EU level, as that is where the competencies for legislation on environmental control standards, employment law, and on diet and nutrition (to note only three) now lie. So one important aspect of the functions of an effective public health department must be to identify the relevant health determinants, to find out where significant decisions on these are taken, and to develop an effective health advocacy function, capable of operating effectively at all relevant levels (and at higher levels in collaboration, where possible, with other public health advocacy operations, operating on behalf of other populations). At EU level, organisations such as the European Public Health Alliance (EPHA) are clearly relevant, and effective UK public health departments should seek to join this most effective organisation, which achieves much through public health advocacy at EU level.

Can we influence the future?

As things stand, public health in England faces a pretty bleak future. Several PCT chief officers have predicted that most PCTs, before handing over public health departments to local government with their funding intact (as is supposedly proposed), will ensure that all identifiable revenue streams that can be removed from public health are indeed stripped out of this funding and diverted to general medical services before any handover takes place. Is it not still possible to persuade the Government that it should seek to protect public health services, and that it should work with the profession to ensure that these services should serve communities in England better than ever before – rather than to endanger – even engender - their effective destruction?

CHIS BIRT

Having a Baby; Improving the 'Patient Experience'

What Women Want and Who Decides

From my own experience of caring for pregnant women I believe that the majority of women want a normal birth, cared for by people they know and trust. They need peace and quiet in order to concentrate on the instinctive nature of giving birth. If one looks at animal behaviour, cats and dogs tend to go into a quiet dark place to give birth. Cows and sheep may stop labouring if moved. We are mammals, and it seems likely that most of us instinctively want to behave in the same way, a view supported by such evidence as we have. It is therefore plausible that the reason for the massive increase in hospital interventions is that the system we have set up is antipathetic to the needs of women in childbirth, for peace, quietness and privacy.

The modern British labour ward, where women hear the cries of other women giving birth, the summons of telephones and bleeps and with its often harsh fluorescent lighting, could almost be designed to interfere with the natural processes of labour. Add the frequent unheralded interruptions like midwives coming to 'get the keys' to the drug cupboard, changes of nursing staff, the doctor's round when five or six people arrive and discuss her 'case', and it is hardly surprising that in some hospitals almost half the women require labour to be strengthened by synthetic oxytocin, to encourage a slightly befuddled uterus to contract.

Continuity of Carer

Ideally women would like to be looked after during labour by one or two people whom they have got to know during the antenatal period. In the past this was achieved by having a domiciliary midwife, sometimes supported by her general practitioner. The close personal relationship built up was probably the reason why, in the 1958 perinatal mortality survey, although the numbers were small, the district midwives achieved better outcomes than the hospital group, despite having a higher proportion of poorer patients and doing

fewer blood tests. The attachment of a midwife to the general practitioner improved his results, but the conclusion drawn by obstetricians was not that midwives had good results but that GPs had less good results than expected. They therefore encouraged women to have their babies in hospital under the care of obstetricians.

The ARM and their Vision 1976

Thirty five years ago, the Association of Radical Midwives (ARM) was formed, following a letter to the Sunday Times from three pupil midwives who had come from the USA, Canada and Australia to train in what they had thought was the home of midwifery. They were shocked by what they found. This was just after the induction rate had risen to its peak in 1974 of 40% in England and 45% in Wales. Oliver Gillie and his team at the Sunday Times ran a campaign against this unnecessarily high rate of intervention, which had shocked the public, and the rate began to fall. The 1974 NHS re-organisation (the first) had brought the domiciliary (now called community) midwives, previously employed by local authorities, under the same management as the hospital midwives and, as the home birth rate fell, their work changed so that they lost the holistic care of women and became postnatal 'nurses'. In hospitals they were in danger of becoming 'obstetric handmaidens', and in many places morale was low.

The Vision

The ARM published their 'Vision' in 1976. The third edition of the Vision, published in 1986 (the year after the WHO published its consensus statement 'Birth is not an Illness') , set out a ten-year plan to achieve their goals:

- The woman was to be the centre of care
- The relationship between mother and midwife was fundamental to good care
- The midwife was unique in her way of working 'with women'
- There needed to be a publicity campaign to put the midwife back in her rightful place in the community and change the perception of the public
- There should be continuity of care for all women
- Midwives' skills should be fully utilised
- There should be provision of community based care and choice for all women
- Maternity services should be accountable to women
- Care should cause no harm to mother or baby

They envisaged that in ten years, 60% of midwives would be working in the community in groups of two to five, based in a variety of settings: community or health centres, homes , hospitals etc. The midwife would be recognised as the portal of entry for pregnant women into care and midwives would care for the majority of healthy pregnant women who fell within 'normal limits'.

The Solution: Primary and Secondary Care Midwives

The key person in providing maternity care for healthy women is the midwife. The current situation, with midwifery shortages, poor deployment and midwives leaving the profession because of frustration, will never change whilst all midwives are managed from the hospital. The labour ward will always take priority over the community.

My solution to these problems and my vision for a better ordered maternity service is for midwives to recognise that medicine is becoming more specialised and to organise themselves, as has the medical profession, into primary and secondary care midwives There would be a national contract for those who do not want to work independently and community midwives would deliver many women in hospital, at least initially, and would have rights of ready access to hospital beds.

Primary care midwives would work in the community, either independently or with contracts from PCTs or their successors, in small groups of two to five as envisioned by the ARM, and as was shown to work by the South East London Midwifery group led by Nicky Leap even when transferred to NHS management. Sadly in 2010 Kings terminated the contract of the Albany Midwives after unproven allegations of poor outcomes for babies despite an evaluation of the practice which had shown good outcomes. Perinatal, mortality was much lower than the borough although they continued to care for high risk women. Breast feeding rates were over 90% and home birth rates about 50%, so it looks like a 'closure on principle' and called an economy cut.

The Independent Midwives Association (IMA) have proposed to government a community midwifery model, 'one mother-one midwife' which would fit in with this idea. Secondary care midwives would work in hospital, and some could specialise. There would, however, be formal opportunities – even expectations – of interchange of ideas and staff between community and hospital.

"Plus ça change…"

Over fifty years after the National Childbirth Trust and AIMS (Association for the Improvement of Maternity Services) were formed, the maternity services, whilst achieving safe outcomes for the baby, still prevent the majority of women from experiencing birth in the fulfilling way that they should be able to. A campaign needs to be mounted by user organisations representing women, midwives and the RCM. The All-Party Parliamentary Group for Maternity Services has been ineffective in changing policy, despite its briefings from the Maternity Care Working Party with its user and multidisciplinary professional representation. Ministers of Health come and go, speak in platitudes and nothing changes.

In the summer of 2006, many small, well- loved maternity units were closed throughout the country, Maternity was added to the Children and Young People's National Service Framework with standards sounding like 'Changing Childbirth' and potentially a vehicle for change. This is still to materialise. In 2007 women's hopes were raised again when Patricia Hewitt launched Maternity Matters. She promised that by 2009 there would be:

- Choice of how to access maternity care. Women will be able to go to a GP or a midwife directly. (In 2006 only 13% saw a midwife without going via the GP)
- Choice of type of antenatal care –women will be able to choose between midwifery care or care led by both doctors and midwives (49% in 2006 had midwifery care only but only 1% were cared for by their own GP. The rest had shared care between hospital doctors and midwives)
- Choice of place of birth-depending on their medical history and circumstances, women and their partners will be able to choose between home births, or giving birth in a midwifery unit or with midwives and doctors in hospital.
- Choice of place of postnatal care-women will be able to choose how and where to access postnatal care.`

Despite a monthly bulletin about progress, golden handshakes for returners, regular workshops to encourage change, money did not reach the frontline and in 2011 these plans have not been realised. A rising birth rate and increasing complexity of cases had not been matched by enhanced recruitment of midwives and units are being closed to help achieve the £20 billion 'efficiency savings' proposed by Sir David Nicholson.

Conclusion

Under *'Equity and Excellence: liberating the NHS'* proposals, commissioning of midwifery services was moved from the proposed National Commissioning Board to GP Consortia - a move which has not pleased midwives. The effect is likely to be dire, with obstetric care being fragmented and the risk of private companies taking over. Midwives might consider becoming social enterprises despite the Albany practice failure in the 1990s. Some might be induced to try this to escape hierarchical, heavy handed, hospital midwifery management. Chelsea and Westminster are already offering a 'personal care service' for £2000, with a two tier service portending when Foundation Trusts private capping is lifted.

Women know what they want and midwives and some obstetricians understand this. Whether women will get the sort of patient-sensitive service, properly coordinated to provide what they need, want and certainly deserve as the mothers of the future children of our country is quite another matter .

WENDY SAVAGE

Adapted from a chapter in Birth and Power: A Savage Enquiry Revisited published 2007 by Middlesex University Press now obtainable from www.pinterand martin.com

Psychiatric Care and General Medicine

The pioneering Mental Health Act of 1959 advocated the integration of psychiatric care into general medical services, in particular that psychiatric services should be located within district general hospitals. This was to counter the stigma associated with psychiatry. From about the mid-1960s DGHs had acute psychiatric inpatient units located within their grounds, often as a separate building. Outpatients shared the same facilities. Also advocated in the Act was integration of functioning of local authority services with psychiatry. This had particular relevance to social workers who had a defined role in implementing the Mental Health Act in respect of non-voluntary psychiatric hospital admissions. Their role has been diluted in the 2008 MHA, but social workers continue to fulfil a statutory function. Nationwide there has been integrated working of social workers within multi-professional teams.

In terms of psychiatric practice, professionalism used to rule OK. Professionalism refers to a high standard of ethics, learning, skill and behavior in carrying out work activities. Psychiatrists like other consultants were employed by Region and the services run by District.

This accentuated the autonomy that consultants used to have. If there was a serious untoward incident warranting an enquiry, it was the professional practice of the psychiatrist that was scrutinised. A body of clinical governance accrued which reflected lessons learned over time, so that the unit had a "memory" of good practice and procedures. As specified by the GMC and Colleges, teaching and mentorship of doctors in training was part of this good practice. Research was integrated into clinical practice, not only by academic psychiatrists, but by a proportion of consultants with solely clinical contracts.

Arrival of General Management

It was Mrs Thatcher's government which commissioned Sir Roy Griffiths to report that the NHS needed a more powerful management ethos. Somebody had to be "in charge". Managers on short-term contracts were appointed to implement hastily conceived Department of Health initiatives which were often of dubious worth. At this juncture consultants who had previously had a considerable say in how service were run and planned started to become regarded by management as opponents of change and even as the enemy. That a small proportion of consultants were spending too much of their working week seeing private patients assisted the promotion of an anti-doctor ethos.

In the USA the closure of the large state mental hospitals was facilitated by the appointment of "case managers" who operated a budget to buy services for their clients. These case managers were often poorly qualified and trained and were therefore cheaper to employ. To compensate for their skills deficiency, regulatory paperwork was devised which included a statement of the clients' needs, a care plan and a risk assessment. The term risk assessment had been borrowed from corporate use in finance and industry. There was no evidence base to support this approach, yet it was imported from the USA with the intention that it would be applied in the field of forensic psychiatry.

'Protocolisation' of Psychiatric Care

Dramatically, in the context of the programme of closure of psychiatric hospitals in the UK, Christopher Clunis who suffered from schizophrenia fatally stabbed Jonathan Zito in the eye in an unprovoked attack at a London tube station. Did the closure of psychiatric hospitals mean that dangerous lunatics were roaming our streets? The public had to be re-assured. The paperwork originally intended for forensic patients was thought fit to apply to all adult psychiatric patients. The three documents mentioned above became incorporated into an elaborate system of rules called the Care Programme Approach. No matter that the patient's needs, risk and hence care plan might change on a weekly basis, so that these documents were always out of date, or that the documents might be so generalised as to apply to

all psychiatric patients. Whenever the Department of Health perceived a deficiency to exist, a "patch" was added to cover the perceived problem. Thus one had to have a child risk screen to apply to the children of our patients, a contingency plan to prevent hospital admission, a care plan for the carer of the patient, a form indicating the patient understood our use of medical records and even a form giving the psychiatrist permission to seek information from the general practitioner about the patient's past medical illnesses.

It takes 4½ hours to complete all of these documents and psychiatrists often ignore them. But managers audit their completion rates and bully other staff to keep these usually useless documents up to date. No-one really reads them. What this represents is a destructive micro-management of integrated multi-professional practice which downplays and over-rides the skills of the clinician in relation to psychiatric history taking, mental state examination and clinical management. Rather than concentrating on what is relevant and important, there is a blunderbuss approach, that all the forms have to be completed for all the patients. Staff spend hours every day at their computer screen getting paperwork up to date and this time reduces their availability for meaningful patient contact. Here's one verse of a prayer by Peter Tyrer, the editor of the British Journal of Psychiatry:

> Mid war and tumult, fire and storms
> Strengthen us we pray with forms
> Thus will thy servants ever be
> A flock of perfect sheep for Thee.

Pricing Care – Commodification and Commissioning

Payment by results will be implemented in psychiatry in April 2011 which is late in comparison with other specialties. In order to fund particular patients each is allocated to one of 21 clusters akin to diagnostic categories. Essentially these are mild, moderate and severe non-psychotic diagnoses and mild, moderate and severe psychotic diagnosis. The allocation is determined by, surprise, surprise, the completion of a questionnaire. This, called the Health of the Nation Outcome Scale (HoNOS) in fact has a reputable evidence base having originally been devised by John Wing of the Institute of Psychiatry's Social Psychiatry Unit though with very different functions in mind. The 21 clusters have an intrinsic interest because they indicate severity which psychiatric diagnosis does not. However the purpose of completion of the process is not epidemiological but financial i.e. to allocate funds for the patients the service is treating. One does not need to be a genius to realise that this system is wide open to "gaming", that if the allocation to the 21 clusters determines funding, that the more severe clusters will be chosen. This was emphasized in training staff for PbR, that we were encouraged not to forget how ill/disabled our patients are. If patients improve and remain in the service it is unlikely that psychiatrists will renew the HoNOS process to allocate a less severe category.

PbR takes no account of teaching and research and at least in these respects has a perspective that is short sighted and narrow.

How GP commissioning will turn out is anyone's guess. Will GPs wish to fund "that nice psychiatrist and community psychiatric nurse"? GPs know little about the community care of those with long-term severe mental illness. Presumably American healthcare companies will be commissioning on their behalf.

Conclusion

What needs to be done? Scrap the elaborate structure of rules and paperwork constituting the Care Programme Approach which undermines the professionalism of clinicians and wastes their time. The way to reduce risk is to have high quality local services. Such services especially those for the severely mentally ill require integrated working of psychiatric teams with local authority social workers and close liaison with general practitioners. The marketisation of health services fragments them and obstructs medium-and long-term strategic planning.

MORRIS BERNADT

Joined Up Care of Long-Term Respiratory Disease: The Example of COPD

Opportunities for Hospital/Community Liaison

The relatively recent introduction of primary care based respiratory teams has opened new prospects for diagnostic, anticipatory and therapeutic management of chronic respiratory disease generally. It calls for a new look at systematic efforts for better coordination across the hospital/community divide as well as ways to achieve the most effective levels of integration of multidisciplinary approaches to management.

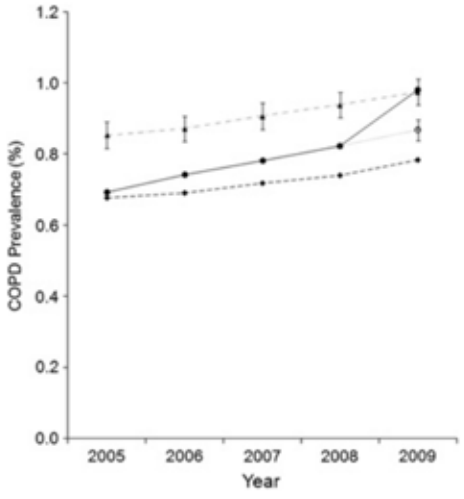
Chronic obstructive pulmonary disease (COPD) is the most prevalent chronic respiratory disorder. A combination of chronic bronchitis and emphysema, it causes breathlessness, exercise limitation and difficulty in performing daily activities. It is slowly progressive and thus associated with aging and co morbidities due to systemic effects of the condition and shared risk factors, in particular smoking. COPD should be given more priority by the NHS. It is estimated to affect 1.4 million people in England,[1] with direct NHS costs of approximately £1bn per year. Acute exacerbations of COPD (AECOPD) are responsible for 12% of acute admissions and more than one million bed days per annum. Despite its high prevalence and impact, knowledge of the condition among members of the public is poor, with most people in the UK not recognising the term "COPD". Symptoms of breathlessness, cough and sputum are insidious and often accepted by patients as "smoker's cough" or a consequence of aging. Many doctors will have been taught about COPD in a "negative" way – with the condition considered untreatable and self-inflicted, perhaps in a less attractive patient group than asthma. The condition is associated with deprivation, lower social class and educational attainment, all of which influence access to healthcare.

New Approaches

The Department of Health collaborating with respiratory organisations including the British Thoracic Society, has developed a national clinical strategy for COPD to address the neglect that COPD has suffered. Consultation was completed in mid 2010, but the strategy has yet to be launched. Some of its recommendations, such as the appointment of SHA leads for COPD, are already being implemented, although the ConDem coalition plans to abolish SHA's.

The problems associated with COPD care in the UK require coordinated action to address them, illustrated with some examples below -

1. Underdiagnosis – the majority of people with airflow obstruction due to COPD have not yet been diagnosed. Informing smokers that they already have abnormal lung function enhances quit rates. Early treatment has been shown to reduce exacerbations. In one survey, 20% of patients admitted to hospital for the first time with an acute exacerbation of COPD had no prior diagnosis of the condition. There are wide variations in the ratio of diagnosed to predicted prevalence of COPD[1]. The historical ad hoc approach to diagnosis is clearly inadequate. The key is to perform screening spirometry in patients with risk factors or symptoms suggesting COPD, perhaps in the context of NHS health checks. A locally enhanced service (LES) for COPD where GP's case-find for a financial incentive for all patients diagnosed can have a dramatic impact on diagnostic rates, as illustrated by the results in Kensington and Chelsea where estimated prevalence caught up with the London average in a single year (and has now exceeded it)[2]



Change in total population COPD prevalence over time in Westminster PCT (lower line, triangles); all London PCT's excluding K&C (upper line, triangles, SEM error bars) and K&C (middle line, circles). The dotted extension of the K&C line shows the projected prevalence and 95% confidence intervals for K&C if the trend in preceding years had continued unchanged. The introduction of the LES in K&C in 2008 was associated with a significant increase in COPD diagnosis in K&C whereas the underlying trend in other PCT's is unchanged.

2. Pulmonary rehabilitation (PR) is the single most effective therapy for COPD apart from smoking cessation. Despite its Grade A evidence base, provision is patchy and in some places extremely poor. Historically, PR has been provided in a hospital setting, but community based services are now being developed. The main issue is under-provision, but newly commissioned community services often compete with, rather than augment, existing provision. An ideal service will coordinate a range of sites and providers based on convenience, disease severity, need for oxygen, transport, frailty and patient preference. As a complex, multidisciplinary intervention PR is thus vulnerable in a competitive system based on cost, easier to assess than value!

3. Lack of systematic provision of services – a recent British Lung Foundation survey has found that provision of services for patients discharged following admission to hospital with an acute exacerbation of COPD varies nationally. Only about half of acute trusts delivered items such as smoking cessation, pulmonary rehabilitation, medication management and specialist follow up systematically.[3,4] A COPD discharge care bundle to improve this has been adopted by NHS London as part of the Commissioning for Quality and Innovation (CQUIN) payment framework.[5]

4. Integration of primary and secondary care – much of COPD care can and should be delivered in the community rather than in secondary care. It is greatly enhanced by an informed and educated patient. A number of models exist – for example, the inner North West London care community has linked PCT's and hospitals to guide COPD provision using Map of Medicine and other IT approaches. One goal of this is to reduce duplication of investigations and provide easy access to previous results as with diabetes care. It is not clear how these arrangements will survive abolition of PCT's. A number of PCT-funded consultant sessions in integrated respiratory care provide expertise and oversight supporting community-based specialist respiratory nurses and physiotherapists.

Many further issues remain to be considered in the organisation of a fully integrated service. These include better patient education in self-management, availability of personalised support, oxygen provision, staff and student training, community networks and meetings of multidisciplinary teams of doctors, nurses, physiotherapists and instructors. In recent times a shared quality improvement agenda has begun to drive cooperation in this area. It is difficult to see how the intensification of market competition, particularly if based on price, can fail to impact adversely on efficient professional relationships, hinder deployment and favour fragmentation of the many different professional elements constituting an effectively coordinated respiratory disease service.

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1. Nacul L, Soljak M, Samarasundera E, et al. COPD in England: a comparison of expected, model-based prevalence and observed prevalence from general practice data. J Public Health 2010:10.1093/pubmed/fdq1031

2. Falzon C, Elkin SL, Kelly JL, et al. Can financial incentives for improvements in healthcare quality enhance identification of COPD in primary care? Thorax 2010 http://www.thorax.bmj.com/content/early/2010/10/14/thx.2010.140913.short?rss=1

3. Jarrold I, Eiser N. BLF and BTS "Ready for home" survey of patients admitted to hospital with COPD: the hospital experience. Thorax 2010; 65:A175

4. Scullion JE, Singh SJ, Morgan MDL. BLF and BTS "Ready for home" survey of the experiences of patients admitted to hospital with COPD. Pt2: the discharge process. Thorax 2010; 65:A175

5. NHS London. CQUIN tools and resources. http://www.london.nhs.uk/your-nhs-in-london/publishing-nhs-data/quality-information/cquin-tools-and-resources, 2011

For Better or For Worse?

Reflections of a Microbiologist on Medical Training

Retired doctors, even those over the age of forty, who look at the way that medical students are now trained in the UK, will find that in most universities it is almost unrecognisable to them. But then so is the NHS.

The Post-War Years

In the latter half of the last Century, as the organisation of clinical practice and public health reshaped itself within the new NHS and Welfare State environment, all aspiring doctors were trained in a similar way regardless of their medical school or university. They would leave their school usually at the age of 18 and go at once to a university and embark on a medical undergraduate course. This generally consisted of a two-year pre-clinical period in which they learned basic sciences, principally anatomy, physiology and biochemistry followed by a three-year clinical period. Much of the first clinical year was spent in the systematic study of pathology, including microbiology. The last two clinical years were mainly spent on the wards in teaching hospitals, in contact with patients under the tutelage of practising doctors. The system used to teach students was largely lecture based with information being delivered mainly through formal lectures and seminars, but, in addition, there was a large element of self-directed study.

The 21st Century – Problem Based Learning

In 2005 the General Medical Council, in part reacting to public/political pressures, published a report, *Tomorrow's Doctors*, which led to dramatic changes both in course structure and teaching methods. *Tomorrows Doctor's* criticised the amount of basic scientific knowledge the students were required to learn, much of which it regarded as unnecessary. The pre-clinical period and anatomy in particular came under attack. The report also recommended that a far greater proportion of the medical learning should be student-centred and self-directed.

The publication of the report coincided with the introduction into medical education of a different teaching method, Problem Based Learning, and stimulated its wider use.

Problem Based Learning(PBL) is not new, having been conceived in the 1920s; nor is it confined to the study of medicine. In the PBL tutorial system small groups of about 8-10 students with a facilitator or tutor are presented with a problem. Working together they analyse it and mark out different aspects that they must then study in their own time. They define their objectives together and, to achieve them, they may attend lectures, read textbooks, undertake practical laboratory examinations or consult an expert. In subsequent tutorials the students share the knowledge they have acquired and decide whether or not their objectives have been met. Lectures still play a part, but power and direction are shifted away from the tutor to the student. PBL met the *Tomorrow's Doctors'* objective of more self-centred and self-directed learning.

Application in the UK

The publication of *Tomorrow's Doctors* and the introduction of PBL boosted changes already being made to medical education, but those changes were neither universal nor uniform. Manchester had adopted a new PBL curriculum in 1994, but the separation of pre-clinical and clinical periods remained. Other universities introduced PBL and now integrated the pre-clinical and clinical periods. Yet others, in particular Oxford and Cambridge, already had a large element of self-centred and self-directed learning and did not introduce PBL. Substantial changes are still being made and there is a wide range of arrangements in other universities between the two 'ends' of the educational spectrum.

Observers have pointed out advantages and disadvantages in both the old and new systems. PBL is said to create students with more enthusiasm for learning who are less detached from clinical medicine. Some leading foreign universities that have adopted PBL have international reputations for excellence, but they spent far more money on its introduction than we did in Britain. Critics of PBL say that it may leave gaps in student education, particularly in anatomy, preparing students inadequately for surgery, academic medicine and microbiology, and discouraging recruitment to those specialties. Inadequately funded PBL has been subjected to great criticism.

Lecture based learning also has its critics who say that it spoon feeds students, and does not prepare them for-self directed learning.

Is it Working?

Which system produces the doctors better prepared to meet today's and tomorrow's clinical, medico-social and ethical challenges? I don't know.

Medical education does not exist merely to satisfy educationalists or attract students. The objective should be to produce doctors with a broader understanding of the technical and environmental causes of and contributors to ill health and so enabled to treat patients better . Unfortunately, a system in which the finances of the universities depend largely on the attractiveness of their courses to the students seems unlikely to encourage an objective assessment. My worries have been exacerbated by conversations with practising hospital consultants to whom I still talk. Most, if not all, have expressed concerns about the quality of their junior staff.

You may not be surprised to learn that as a retired microbiologist, I worry about the ability of newly trained doctors to treat and control infection. There are dozens of different species of bacteria. They may look and behave differently, affect different systems and produce different symptoms. They may be sensitive to and become resistant to a huge range of antibiotics by a variety of highly complex mechanisms. How can someone who has never been taught even the differences between the bacterial species select from the dozens of antibiotics available the best agent with which to treat a patient? It is more than tossing a coin to make a choice between two with an S beside their names on a sensitivity report. New modes of resistance are appearing with monotonous regularity and the bacterial march towards universal resistance seems inexorable. Doctors who don't know enough, who do little more than stick a pin in a list, can only accelerate that process. If universal resistance were ever to become prevalent the seriousness of the consequences for the whole of medicine could not be overestimated.

If doctors never learn the routes of bacterial transmission or the principles of infection control, how are they to know the stringent rules of patient isolation. Are they just going to replace understanding by blind obedience to decrees produced by committees and then obediently take off their ties and cut the sleeves off their white coats, neither of which has been shown to do any good at all? To the ignorant it all seems so simple. Only the well educated know that it is not.

Changing Social Expectations

Other changes in our society have had a profound effect upon training of junior doctors. Apart from the fact that they have to learn much more than I did they have less time to learn it. The reduction in the amount of time that they are allowed to work brought about by European Working Time Directive did more than prevent the exploitation of junior doctors. It forced the introduction in hospitals of shift systems that, at a stroke, slashed the amount of time they could spend in the company of more experienced doctors and cut by half the amount of time the young doctor could spend gaining experience of treating sick patients. Moreover, it eroded the whole concept of continuous patient care. The management of individual patients used to be the responsibility of a single medical team, day and night. That no longer appears to be the case. The mathematical problem of providing 24-hour cover within the new concepts of 'work/life balance' was solved at the expense of the erosion of the concept of continuous clinical responsibility.

Training in a 'new' NHS

Have the succession of NHS reorganisations and reforms and altered methods and conditions of training changed the attitude of junior doctors today? I don't know the answer, but when I read about one hospital scandal after another I can't help wondering where the doctors were. A young doctor in training who should see every patient at least once a day should surely notice if patients are lying in their own faeces for 24 hours. They should surely have raised the bedclothes then the roof. If patients are so dehydrated and thirsty that they are forced to drink water from flower vases don't their doctors react? Or is supplying a glass of water considered to be not their job?

So this is my question. Have all educational changes and all the changes in working practice resulted in better patient care? The answer is not self-evident. I don't know and I suspect that you don't either.

I think we should find out. We need a wholly independent assessment of the new educational systems and working practices to find out if they provide not only more knowledgeable doctors but also more humane doctors - to discover if have they resulted in better patient care in the broadest sense. That assessment should be carried out not by educationalists or universities or civil servants, for they are interested parties, but by a wholly independent team of investigators. If things are found to be better now then we can all heave a sigh of relief, but if they are not we need to know. Predictably, there will be no simple answer but we should not be deterred from asking the questions. The systems which we have adopted may have provided convenient solutions to knotty financial, administrative and logistic problems but at what cost to our professional performance? In this case ignorance is not bliss.

DR NORMAN SIMMONS.
Emeritus Consultant in Microbiology, Guy's Hospital

Another Dodgy Dossier?

One of the boldest statements in the White Paper was that the changes would reduce the administrative costs of the NHS by 45 % over 5 years.

In 1995 Peter Draper in a publication "In practice: the NHS market" written for NHSCA showed, using official figures, that the introduction of the Internal Market in the early 90's had almost doubled administrative costs from 6% to 11.7%. of the total budget. This was widely publicized but never challenged.

Since then a much more complex market system has been introduced, with Payment by Results etc which must have meant a further substantial increase in these costs but it is no longer possible to obtain the necessary figures from the DOH. Even the Health Select Committee had difficulty when compiling its report on Commissioning, the wording of their report indicating great frustration with the inability, or unwillingness, of the Department to produce the figures. Eventually it offered a figure of 14% as the current administrative costs.

Following Andrew Lansley's recent nightly interviews on Radio 4 PM, the paucity of time for questions and the offer for them to be answered if put to him later, I saw an opportunity and submitted this question:-

Dear Mr Lansley,
One of the objectives you have set out is to reduce administrative costs by 45% over 4 years.
I am sure you will agree that in order for us to be able to judge, at the end of that time, what success has been achieved it is necessary to know 45% of what, in other words what those costs are now.
In the interests of transparency will you now publish the current costs?
Yours sincerely
Peter Fisher

Over a month later I received the following from a DOH official

Thank you for your email of 21 January to Andrew Lansley about Government's plans to reduce administration costs in the NHS. I have been asked to reply on his behalf.

As you may know, the White Paper Equity and excellence: Liberating the NHS, has shaped the Health and Social Care Bill, which was presented to Parliament on 19 January. The Bill sets out the Governments proposals for transforming the quality of commissioning by devolving decision making to local consortia of GP practices supported by an independent NHS Commissioning Board.

The Government's proposals will remove the unnecessary layers of management that have built up over the last ten years as layers of national and regional organisations have accumulated, resulting in excessive bureaucracy, inefficiency and duplication. Management costs in primary care trusts and strategic health authorities have increased by over £1billion since 2002/03, with over £220million of the increase taking place during 2009/10. Over the next four years, NHS management costs will be reduced by more than 45 per cent.

The direct cost savings come from the reduction in administrative spending. This is currently £5.1billion per year, and will be reduced to £3.4billion by 2014/15. This means that there will be a direct cost-saving of £1.7billion per year from 2014/15 onwards. The upfront costs of transition are expected to be more than recouped by the end of 2012/13.

Reduction on this scale can be realised only by radically simplifying the architecture of the health and care system. You can read about the Bill on the Department's website, at www.dh.gov.uk/healthandsocialcarebill.

I have gone back to the White Paper. It says quite unequivocally in para 5.3 that "over the next 4 years we will reduce the NHS's management costs by more than 45%" .

I have asked for clarification as to whether the £5.1billion referred to in the response to me is only the management costs of PCTs plus SHAs or that of the NHS as a whole. If the former it is a much smaller matter than the White Paper claim, if the latter it is clearly inaccurate.

The response to the Health Committee gave a figure of 14% or £14billion (with a budget of around £100 billion this is much the same thing) This is widely regarded as the minimum possible estimate.

Richard Taylor has since sent me the relevant pages of the Health Committee minutes which reveal a Department totally uncertain how to ascertain administrative costs.

The eye catching 45% claim is clearly not worth the paper it is written on.

PETER FISHER

Meeting with Stephen Dorrell MP

Jacky Davis and I met Mr Dorrell, chair of the Health Committee and former Secretary of State, at Portcullis House on 1st February. Clive Peedell had been coming with us but had to cancel due to pressure of work.

Our meeting started late, due to Health Committee business but was then allowed to overrun so that we got the full 45 minutes which had been arranged. Whilst waiting we talked to an aide who asked questions and took notes about NHSCA, its history and purpose, which saved time later.

When Mr Dorrell arrived, we explained that we wished to bring to his attention the dangers and inconsistencies of the White paper, now Bill and said that, having lived through numerous NHS reorganizations, we were firmly of the view that any one wanting to do this yet again should be obliged to prove the case beyond doubt, a concept with which he agreed. We pointed out that this had not been done as one of the main arguments, that cancer and heart attack results were lagging behind other countries, had been shown by John Appleby and others to be incorrect.

The other main argument being used was merely that we had to "modernize". He agreed that this was a meaningless word and would not personally use it.

He claimed to be a "critical friend" of the Bill and did not agree with everything in it but regarded the proposed changes as evolutionary and nothing new, merely an extension of what had gone before. He thought the GP consortia would end up much like PCTs and would not himself have abolished the latter. To the question of why therefore its author had described the Bill as the biggest shake-up since 1948 he had no answer other than to shrug his shoulders, as if distancing himself somewhat from Andrew Lansley.

The threats posed to NHS hospitals on which their catchment populations relied were outlined, including loss of income to non NHS institutions which were able to cherry pick the more straightforward procedures and undercut the price, the destabilizing effect of one service being lost from a general hospital and the effects on training. We expressed our concern about the further extension of commercial competition and opportunities for profit making organizations, reminding him of the number of times private health companies in the US had been prosecuted for fraud and the risks involved should they expand activities here. He repeated his belief in the value of competition but we pointed out that there had always been competition in the NHS, based on results and reputation not commercial factors.

We outlined ways in which the barriers between primary and secondary care could be broken down, patients given choice (which they had before the market introduced contracts), care delivered more cost effectively and bureaucracy reduced by simplifying the system without major upheaval. This would achieve all the proclaimed objectives of the Bill except a greater role for the private sector, so it had to be concluded that this greater role was the main driver behind the proposals.

We talked of the costs of the market system and reminded him of the difficulty his Committee had encountered in trying to get figures from the Department but contrary to the wording in the Committee's report, he did not now seem to attach much importance to it. We referred also to the Committee's finding that after 20 years of trying to make commissioning work success remained elusive and asked why the insistence on trying one more time instead of moving on, as the rest of the UK is doing.

On specific points, we tried to get clarification on details of consortium commissioning, having been puzzled as to how patients could choose to go anywhere, if their local consortium was making contracts with some providers and not others. Several of our GP contacts have told us that "any willing provider" , if accepted by the Care Quality Commission and Monitor, would go on a national database from which individual patients could choose, with the role of the consortium merely to pay the bill. Mr Dorrell acknowledged that this was so but only, he said, for elective procedures not "the rest". What happens with "the rest" was not made clear, suggesting that key parts of the Bill have still not been thought through, despite its 6 year gestation period.

(Subsequent to the meeting, it appears that the national database will be applied much more widely and that, according to Lib Dem Health Minister Paul Burstow, very

few GPs will have any involvement with commissioning and contracting will be the responsibility of the National Commissioning Board, not GP consortia).

We concluded by drawing attention to the growing weight of professional and public opinion against the Bill and reminding him of its capacity to be the Coalition's Poll Tax. Jacky was able to illustrate this quite dramatically by reporting that her mother, a life long Conservative, had torn up her card because of the Bill.

As we left we offered, should there be a willingness to reconsider key features, to meet again to discuss alternative methods of improving the NHS and making it more cost effective, using public service rather than commercial principles.

Meeting with Diane Abbott MP, Shadow Minister for Public Health

Wendy Savage, Paola Domizio and I went to this meeting on 8th February. We had been invited to continue a discussion started at a KONP event at the House of Commons.

There was, as expected, agreement on the need to oppose the Health and Social Care Bill and details of the parliamentary procedure were clarified. The Bill being then at Committee stage we asked for and received Ms Abbott's views on which members of the Committee might be worth approaching.

We stressed, as we had done at the earlier meeting, that we saw it as essential for the Labour Party to rethink its own attitude to the use of market forces in the delivery of health care without which opposing the Bill would be ineffective.

This was particularly important as, far from talking now about "the biggest shake-up since 1948", leading Conservatives were justifying their policies by describing them as merely a continuation of what the previous administration had been doing. When asked directly whether she thought such a reappraisal of policy was likely Ms Abbott was unfortunately unable to give us any reassurance.

A number of other aspects were raised, including the damaging effects on training but the meeting was then curtailed as she was called away on parliamentary business.

We continued discussion for a while with her aide, who took notes of some of our detailed criticism of the Bill.

PETER FISHER

NHS Integration Primary and Community Care Services

NHS historians may look back at the 1980's and agree that this was the heyday of general practice and primary care. Not only had general practice become first choice for many medical graduates but many practices were constituted as active primary health care teams (PHCTs). At their best, these practice teams – consisting of GPs, practice nurses and managers - midwives and health visitors, district and psychiatric nurses and often social workers, represented true integration of community and primary care services.

The Impact of the 'Reforms'

The virtual demise of PHCTs through the market reconfigurations of the 1990's has been a retrograde step. As this sort of teamwork integrating clinical and social services has been shaken apart, more and more work has been devolved from hospitals to the community, actually increasing the need for PHCTs As the community has taken on higher volumes of more complex patient care we have increasingly found ourselves forced to work in relative isolation from each other. Professional relationships have withered away; what was often daily contact between say a GP and health visitor or district nurse, is now an occasional, hurried conversation in the corridor. The quality time available at a weekly PHCT meeting to discuss complex or worrying cases has disappeared. Getting to know and trust each other and using that relationship for the benefit of patients has been all but lost.

Yet governments, NHS managers, health care theorists talk ever more about integrated services. Could we ever get that genie out of the bottle again? How could it be made to work?

The Future Prospect

The outlook in the face of the massively destructive NHS and Social Care Bill is not good. The Bill attempts to reduce health service provision to a simple model of market trading between patient-purchasers and physician-providers (though actually between unaccountable proxies appointed to act on their behalves!). Crude market competition is to become the norm and profit margins could well outrank relative clinical need in determining

what and how health and social care services are provided in the future. GP 'commissioners' may be reduced to little more than simple bill payers; they will have little if any individual choice in the new system and will have to conform to commissioning ordinances passed down to them and as defined below.

These much publicised GP Commissioning Consortia will hold the local NHS budget but their shaping of local services might be better described as a decommissioning process. It is they who will be forced to grapple with finding their share of the £20bn efficiency savings to be made in the next four years, a daunting prospect as health care inflation balloons above the general inflation index to which budget increases will be restricted.

The Any Willing Provider Policy (AWP) will further limit the ability of the GP members of the Consortia to shape local services (as advertised by the Government) because AWPs will have access to the NHS as of right once licensed. Bad news for GPs wishing to preserve their comprehensive local NHS Hospital if cheaper AWP bids are commissioned. It remains to be seen just how the Consortium selection of provider can be reconciled with the much vaunted individual patient's unrestricted freedom of choice!

The risk of fragmentation of effort and of services will be much magnified if competitive tendering for clinical services becomes obligatory. It would chop up health and social care activities into neat, marketable packages in which cheapness cannot fail to be the major determinant. This inevitably pulls in the opposite direction to integration and fragments what should be collaborating, patient-friendly systems. What is an appropriate response?

Clarifying Issues

First, to dispel a myth about 'commissioning'. This term was introduced as a euphemism for 'purchasing' to camouflage the market. However, it can be rehabilitated and the working definition I use is:

the process of gathering and analysing the wants and needs of a population, of identifying the services required to meet those needs and of monitoring those services and their outcomes as they are delivered.

Used in this way, commissioning does not imply a purchaser/provider split and has nothing to do with market philosophy. It is a planning device, something with which all clinicians could and should be involved at their own appropriate level and many GPs already are. If GPs and other clinicians with public involvement were to get real control of this type of commissioning it could turn the NHS in healthy and radical directions.

Local groups of GPs, consultants, allied professional disciplinary groups, patient representatives and other concerned parties could develop pathways of care from the patient's home to the GP surgery, hospital out patients and, if necessary, to hospital admission. Local guidelines and protocols could be compared with those in other clinical settings. Proposed pathways could be tested and incrementally improved by the processes of audit and continuous quality improvement (CQI). No commercially driven market mechanisms or private providers are needed.

Further Measures to Coordinate Activities

In the community we could resurrect the PHCT and enhance its importance, membership and scope. Instead of 'out-reach' and 'in-reach' there could perhaps be pathways teams so that all the different professions and actual people delivering care – along with those receiving it - could meet and share their experience and expertise to improve 'the patient experience'. Audit would be common place, built in to patients' passage through the system with no divide between primary and secondary care. Computer systems can readily support this kind of integration, also facilitating better sharing of information . This level of coordinated activity could greatly enhance the level of patient care; the time and resources needed for it should be embodied in all clinical planning activities. It was approached in the late 1990s by the original Primary Care Groups (PCGs), but lost when the conversion to Primary Care Trust (PCT) status was forced at the expense of the blossoming involvement of individual health care professionals and teams.

The clock can not be turned back so we must be prepared to meet new, not always welcome, conditions – to do our best to limit the damage threatened by the proposed Health Bill, to maintain and improve links between colleagues across the primary secondary divide and between community health services and social care; and to keep the dream of the supremacy of equity and social purpose in health care alive. Surely it will live to find a place in a future, more rational NHS.

DR RON SINGER
Recently retired GP and President, Medical Practitioners' Union (Unite)

The Health and Social Care Bill, February 2011

The Health and Social Care Bill contains the Coalition government's legislation to enable the NHS to be privatised and massively cut.

1) **The main aim of the White Paper is to hand over of the provision of NHS care to private companies.**
This policy is called " patient choice". A competitive market is to be enforced.

2) **To impel and accelerate this change, commissioning in England is to be privatised**
GPs must amalgamate into consortia. These GP commissioning consortia (GPCCs) are given the task of commissioning the bulk of the NHS care under the control of a National Commissioning Board (NCB).

The GPCCs and the NCB could be largely run by private interests.

The appointed NCB will probably contain figures from large health corporations. The bill gives the NCB draconian powers over the GPCCs to enforce their adoption of new pathways of delivery of care involving private commercial companies. The NCB performance manages the consortia, including financial scrutiny and powers to close them, merge them or parachute in private companies to run them.

GPCCs are likely to be of such a large size, (probably 50 to 70 consortia) the size of clusters of PCTs, that they would become dominated by a small clique of GPs.

The bill enables this leadership to turn to the private sector to do the commissioning for them. (Already a £20m contract has been given to KPMG and partners to "support commissioning" in London).

The present commissioners, the Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) a publicly run bureaucracy are to be ended by 2013.

3) **GP commissioning will not be GP commissioning.**

The Government is hiding this plan to privatise commissioning, by saying that GPs will be in control of 80% of the NHS commissioning budget, through GPCCs.

4) **The role of the new commissioning bodies is two fold**
a) PRIVATISATION to outsource clinical care
b) CUTS to reduce and remove clinical care on a massive scale.

a) The new commissioners must enforce the market.

The new commissioners must implement "patient choice", by ending the present position of " NHS as preferred provider' and changing to an "any willing provider" policy.

The new "market" of competing providers would be regulated by MONITOR, which would introduce PRICE COMPETITION by abolishing national PBR tariffs, and deciding "best practice" tariffs. Commodification of care through Payments by results tariffs is being extended to mental health and primary care.

b) CUTs

The GPCCs would take over the debts of the PCTs and then have to ration care on a massive scale as they would be held responsible for cutting the English NHS budget by £20bn by 2015 on the QIPP initiative.

The nominally responsible GPs would then be blamed for the withdrawal of care and treatments and for closing hospitals.

CUTs will see the publicly owned infrastructure of the NHS continuing to be closed down, sold off and privatised as the cuts proceed and the private companies move in (e.g. PFI and LIFT buildings, privatisation of NHS procurement, IT contracts, privatisation of ambulance and pathology services, ISTCs etc.).

CUTs will see the the new commissioners instructed to continue the "reconfiguration" of NHS care by driving down GP referrals of patients to hospital, and removing hospital care. The impact assessments of the bill envisage the

bulk of the cuts coming from hospital closures and sell offs and job losses.

The Darzi decimation of District General Hospitals is back

5) **The aim is to "liberate" the NHS from the structures founded in 1948;**
*publicly owned hospitals and infrastructure,
*publicly provided service by staff on national terms and conditions and pensions
*national system of education and training

so that private companies can profit from NHS government contracts.

6) **Legislation will enable the three parts of the NHS to be handed over to corporate private companies.**
Community care is to be removed from direct provision by April 2011 in line with previous policy, independent GP practitioners will be finished and the nationalised publicly owned hospital network denationalised.

7) **British general practice will be destroyed**
GPs must join consortia effectively herding them into giant primary care organisations. Private corporations could bid to run them, extending and overtaking the drive of the Darzi initiative to federate GPs into commercially run polyclinics with GPs on APMS contracts. Independent practitioner status of GPs will be eventually ended as their contract is terminated and the new requirement for GPs to join consortia imposed. Traditional British general practice with its continuity of care and prioritisation of clinical needs of the patient, will go, as practice boundaries are removed and as GPs are forced to abide by the consortia's rationing, referral and prescribing policies.

The direction of travel is that the new consortia will end up holding the GP contracts, as they are given powers to performance-manage GPs. Thus these new consortia could not only end up employing large numbers of GPs, but also have large commissioning powers, like embryonic Health maintenance Organisations.

8) **The hospitals are to be denationalised and closed on a massive scale.**
They must all become Foundation trust businesses and then convert to "social enterprises". Social enterprises do not have to adhere to national terms and conditions or give NHS pensions to their staff. The latter are the transition stage to fully-fledged private hospitals.

The bill lifts the cap on FTs treating private patients. The bill will make it easier for FTs to sell assets. The bill removes Section 45 of the NHS Act 2006 which prevents FTs from disposing of "protected property" without the regulators approval. The bill extends most of the insolvency rules that apply to companies to FTs , making it easier for lenders to recoup loans in the event of 'failure', which could open up a market for lending to FTs.

Hospitals must make money on PBR or go bankrupt and 'fail' and must not be 'bailed out.' The scene is set for mass hospital closures.

9) **The consequences for NHS staff are the loss of thousands of posts through cuts, and the forcible transfer of employment to private companies with removal of national terms and conditions and NHS pensions.**
A cheap casual disorganised workforce is to replace a workforce protected by union collective bargaining.

10) **The consequence for patients** is the rapid and drastic removal of care provided; fewer hospitals miles from home, the decimation of care for the elderly and those with long term illnesses, and the withdrawal of all types of operations and treatments.

Conclusion - The bill's proposals aim to end the NHS as predominantly publicly owned and provided system of healthcare funded by taxation, with the right of every citizen to have access to comprehensive, high quality healthcare, free at the point of need. It aims to replace it with a truncated minimal service commissioned and run by big business. The basis would be laid for patient charges and health insurance.

PERSONAL VIEW, ANNA ATHOW
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Scotland - The Facts

In the maelstrom of discussion over the coalition's plans for the English NHS, which we in Scotland can only watch with fascinated horror, I am sending a small piece of good news indicating that there is an evidence-based alternative to the "mad scientists" bent on radical reform south of Hadrian's wall.

In the course of obtaining information about Scottish waiting lists and waiting times, I was given a link by an ISD Scotland statistician to the recent publication by the Office of National Statistics of comparisons of waiting times for 11 elective hospital procedures for the four countries of the UK between 2005-06 and 2009-10. These have been standardised for comparative purposes; I have averaged the 50th and 90th percentile waits for the eleven procedures and placed them in rank order by country for each year. Waiting times for Scotland and England are comparable, with Northern Ireland and Wales lagging; all four countries show substantial reductions in waiting times over the last five years. Scotland ranks first for four out of five years for median waiting times (50th percentile) and first for three out of five years for 90th percentile waits.

The Scottish results were obtained despite the devolved administration abandoning the internal market and payment by results in 2003. In 2008-09, only 7690 NHS inpatients and day cases (0.6% of the total) were treated in Independent Hospitals. Scotland's single ISTC in Stracathro treated a small number of patients in 2007-08 and was then taken over by the public sector.

The results confirm other evidence discussed previously that, with respect to clinical activity, demand and supply in the primary, secondary and tertiary sectors of the Scottish NHS have been in broad equilibrium in the last five years. Claims by Julian Le Grand et al that Scottish waiting lists and waiting times lag behind English waiting times are unsupported by this recent evidence. I don't suppose this will have any impact on the neoliberal ideologues.

MATTHEW DUNNIGAN

Average waiting times between referral and admission for 11 elective hospital procedures [1] 2005-06 to 2009-10 [2]

	England	Scotland	Wales	Northern
	50th percentile of days waited (rank order)			
2005-06	89 (2nd)	86 (Ist)	133 (4th)	125 (3rd)
2006-07	86 (2nd)	72 (Ist)	128 (4th)	104 (3rd)
2007-08	65 (2nd)	59 (Ist)	107 (4th)	90 (3rd)
2008-09	49 (Ist)	53 (2nd)	83 (4th)	82 (3rd)
2009-10	50 (2nd)	48 (Ist)	72 (4th)	70 (3rd)
	90th percentile of days waited (rank order)			
2005-06	180 (Ist)	191 (2nd)	298 (3rd)	334 (4th)
2006-07	157 (2nd)	152 (1st)	254 (4th)	242 (3rd)
2007-08	128 (2nd)	121 (1st)	213 (4th)	183 (3rd)
2008-09	99 (1st)	100 (2nd)	166 (4th)	153 (3rd)
2009-10	100 (2nd)	97 (1st)	149 (4th)	139 (3rd)

1. Procedures:- Angioplasty, Angiography, Bypass Surgery, Cataract Surgery, Hip Replacement, Knee Replacement, Endoscope of Bladder, Endoscope of Upper Gastrointestinal Tract, Hernia Repair, Tonsillectomy and Adenoidectomy, Varicose Surgery.
2. United Kingdom Health Statistics 2010; Tables 6.6 a-f; Edition No 4; Official National Statistics

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