
NHSCA

EDITORIAL September 2013

Hope springs eternal

The finale of the recent Chester Mystery Plays depicted the Last Judgement and the fate of those unrepentant souls who in life had chosen sin, exemplified in an earlier scene by the worship of money. They were firmly sent by Lucifer into the smoke and flickering flames of an extremely hot and nasty eternity. Very few found themselves ushered the other way to a more comfortable fate. We were reminded of the short verse by Oliver Wendell Holmes:

*God's plan made a hopeful beginning
But man spoiled his chances by sinning.
We trust that the story will end in God's glory,
But at present the other side's winning.*

The author was a lawyer, poet, philosopher and physician who as dean of Harvard Medical School suggested the enrolment of women and sanctioned the admission of the first African-American undergraduates, although this was later reversed by pressure of public opinion. He also created the term 'anaesthesia'.

Aneurin Bevan's plan for the NHS certainly made a hopeful beginning but 'the other side' is working alarmingly fast to demolish this vital service and in so many ways has been winning. The Coalition has mendaciously seized the opportunity of the financial crisis to persuade people of the dangerous idea that the NHS is unaffordable. Meanwhile, Nicholson's £20 billion 'efficiency saving' has forced Trusts to reduce staff numbers and an RCN survey has found that most nurses are now too busy to provide all the care they

should. In their recent reports Berwick, Keogh and Francis all mentioned inadequate nurse staffing, but it seems there is to be no mandatory minimum level.

Many patients have commented to me on the contrast between their own good experience of the NHS and the horror stories they constantly see and hear in the media, although relatively few seem to be under any illusions about the origin and intentions of all this adverse publicity. '13,000 needless deaths in 14 different hospitals' made memorable headlines the weekend before the publication of the recent Keogh report. This zombie statistic is now fixed in public consciousness even though in his report Sir Bruce had specifically warned against any such assumption. As David Spiegelhalter (BMJ, August 10th) says, 'it is enough to make a statistician sob' that 'most of the media and Parliament seem incapable of understanding that half of all Trusts will have above expected mortality'.

Where there may have been problems, how will they be dealt with? By more inspections, it seems, with a new Chief Inspector of Hospitals leading 'armies' of doctors and nurses leaving their clinical duties to check up on Trusts elsewhere. Patients, carers and other members of the public are to be included in the inspection teams (and will be paid). David Levy's splendid 'organogram' in the last Newsletter shows how complicated the regulatory structures had already become even before these new bodies were added.

In the September 2013 issue of the NHSCA Newsletter. Editorial: **Andrea Franks**, pg 2; **David Nicholl** on Commissioning - the next big scandal for the NHS, pg 3; **Andrea Spyropoulos**: Times Change, Principles Endure, pg 6; **Cathy White** on the NHS in Wales, pg 8; **John R Ashton**: Why We Need A Citizen's Coalition to Save The NHS, pg 11; **Matthew Dunnigan** on NHS Scotland vs England, pg 13; **Mark Aitken**: Unwinding The NHS Downward Spiral, pg 16; **Chris Bunker** on Commissioning – a wasteful process but we must get involved, pg 18;

Jeremy Hunt may be calling for integrated care, with closer working between providers, but the whole thrust of Lansley's Act is to fragment the entire system and replace co-operation with competition. The market is the problem, increasing complexity and costs while clinicians waste endless hours discussing tariffs or preparing bids for services which have been put out to tender. Since Section 75 came into force, about 100 clinical services worth £1.5 billion have almost all gone to the private sector, while Capita and Circle together are said to be interested in a huge £1 billion contract for Cambridgeshire community services. Surely this is collusion, not competition. In Nottingham, entire outpatient services, Dermatology and several others, have been taken over by Circle and this is apparently compromising SpR training. Another alarming recent development is the sale of Plasma Resources UK to a US private equity firm with links to Mitt Romney and a reputation for aggressive asset-stripping.

Although NHS failings are widely publicised, we hear far less about disasters in outsourced services. Channel 4 broadcast a 'Dispatches' programme in July in which a Harmoni manager confessed to an undercover reporter that their 111 service was unsafe at weekends, but BBC coverage is still almost non-existent. The BBC website did contain a report on the privately run Surgicentre in Stevenage which has been returned to the NHS after its licence was suspended following deaths, avoidable blindness and the loss of 8,500 casenotes, but it hardly made the headlines we should have expected. Serco's falsification of figures in their inadequate GP OOH services in Cornwall was mentioned in several papers but barely at all in the national news.

An area which has certainly been in the news is south London, where the effects of enormously costly PFI contracts such as that at QE2 Woolwich are plain for all to see. As always, hospitals with no PFI, such as Lewisham, are also threatened. Elsewhere, the consequences of the huge Bart's and the London PFI, and so many around the country, still continue. It seems almost incredible that a new Carillion PFI contract for the Royal Liverpool Hospital is still progressing in spite of continued local KONP campaigning and all the evidence that payments will be unaffordable.

We can only gaze enviously across our borders towards the devolved nations. There are still

severe financial pressures in Scotland and Wales, but Cathy White's article on NHS Wales shows a far pleasanter and more sensible approach than we have in England. Matthew Dunnigan's comparison of activity in the English and Scottish NHS makes an important and interesting contrast which he is looking at in more detail.

But all is certainly not lost and there are several encouraging developments. The judgement that Jeremy Hunt had acted illegally in the case of Lewisham was a real success and was widely reported. In recent weeks too there have been more and more articles questioning the merits of outsourcing, not just in the NHS but in prisons, water, offender tagging, disability assessments and many more. A new pressure group 'We own it' has started. 'SOS NHS' has been high in the Guardian Bookshop best-sellers list for a month with glowing reviews and has been reprinted three times, a real success. Awareness does at last seem to be spreading. Among GPs, two CCG Chairs have recently resigned, while Western Cheshire CCG has voted unanimously not to outsource their community services. Our KONP group hopes to persuade other local CCGs to do the same.

Roger Phillips, a Radio Merseyside journalist, whose father was a Manchester GP, spoke recently at a local medical society dinner. He issued a clarion call to the profession to make its voice heard, a voice more respected than any MP and less tainted (though sadly not untainted) by personal financial interests than so many in Parliament. It is tragic that the BMA and, even more, most of the Royal Colleges, have failed in their duty to do this.

Oliver Wendell Holmes also said that the important thing is not so much where we are but in which direction we are travelling. We have been taken in completely the wrong direction, but let us hope that the tide may just be turning. The soundness of Bevan's health service seemed absolute for half a century but the actions of recent governments have shaken to the roots the security of its concept. When Pandora lifted the lid of her previously secure jar, Hope at least remained to afford some encouragement.

ANDREA FRANKS
Guest Editor

Commissioning - the next big scandal for the NHS?

David Nicholl

Since the 1st April implementation of the Health and Social Care Act, much of the focus in the media in relation to the NHS has been concerned with A&E problems, variance in hospital mortality rates and NHS111. However, the next big issue that I think will cause widespread controversy is the profound changes in relation to commissioning of treatments. In an era where we keep being told “there is no extra money”, how services are commissioned, and paid for, in the NHS will be crucial.

What follows is very much a personal view, as to be honest I don't know anyone who actually has a clear view on how things are organized, such is the speed of change.

For example, I am the neurology representative for the West Midlands on the Clinical Reference Group (CRG) for neuroscience. At the last count there are no less than 74 different specialty specific CRGs. CRGs are “driven by a commitment to ensure equity across specialised services. This means ensuring that patients who require treatment from any of the specialised services have equitable access to those services, regardless of where they live, and that each of the services is of the highest possible quality.”

In plain English, that means trying to define what is specialised versus general for any given specialty. Specialised services will be commissioned nationally via NHS England, whereas the CCGs (clinical commissioning groups) will determine what services get commissioned locally. This could lead to all sorts of controversies over what should be considered specialised. For example, within the neuroscience CRG, should services for Parkinson's disease be considered specialised or general? This could lead to ‘gaming’ between neurology and elderly care-one offering a more expensive service versus the other. On the other hand, if someone is offering a more complex service for Parkinson's disease- eg an Apomorphine clinic, an atypical Parkinsonism clinic, a Duodopa service- should the Trust be able to legitimately argue for a specialised service? If so how should the CRG answer these issues at a

national level to avoid a postcode lottery? And that is just one neurological condition, do we need to define specialised versus general for ALL neurological disorders?

One can easily see that exactly the same confusion will arise for every other disorder and specialty. Which dermatological conditions need to be seen by a specialist? In rheumatology, for patients with lupus, what are the commissioning arrangements for drugs like Rituximab? The list will be almost infinite.

If you think that was getting complicated, one aspect where I am still trying to work out the difference is how CRGs interact with other bodies such as the SCNs...that's strategic clinical networks, which are “hosted and funded by the NHS Commissioning Board (NHS CB), and will cover conditions or patient groups where improvements can be made through an integrated, whole system approach”. However SCNs will have a more focused approach on specific areas, i.e Cancer; Cardiovascular; Maternity and Children; Mental health, Dementia and neurological conditions.

The hope is that SCNs will be able to drive forward positive change nationally akin to how the National Stroke Strategy and stroke networks did for stroke, although ultimately it will be up to the CCGs to decide whether the SCNs recommendations are to be acted upon and followed or ignored.

Finally there is how the SCNs interact with the Clinical Senate. “Twelve Clinical Senates were established across England, broadly based around major patient flows into specialist and tertiary centre. The footprint of each area maps into Clinical Commissioning Group (CCG) and Local Authority boundaries. There is one Clinical Senate for each geographical area”. Although Clinical Senates are there to provide more specialist secondary care input, again it will be up to CCGs whether they accept their advice or not.

Given the complexities of all of this, what

should we do given that many of us warned the Government that this would end up in making a very expensive fragmented health service? Should we all move to another region of the UK apart from England? Assuming you aren't moving, I would argue that those clinicians in England should get involved with these new bodies for three very simple reasons:

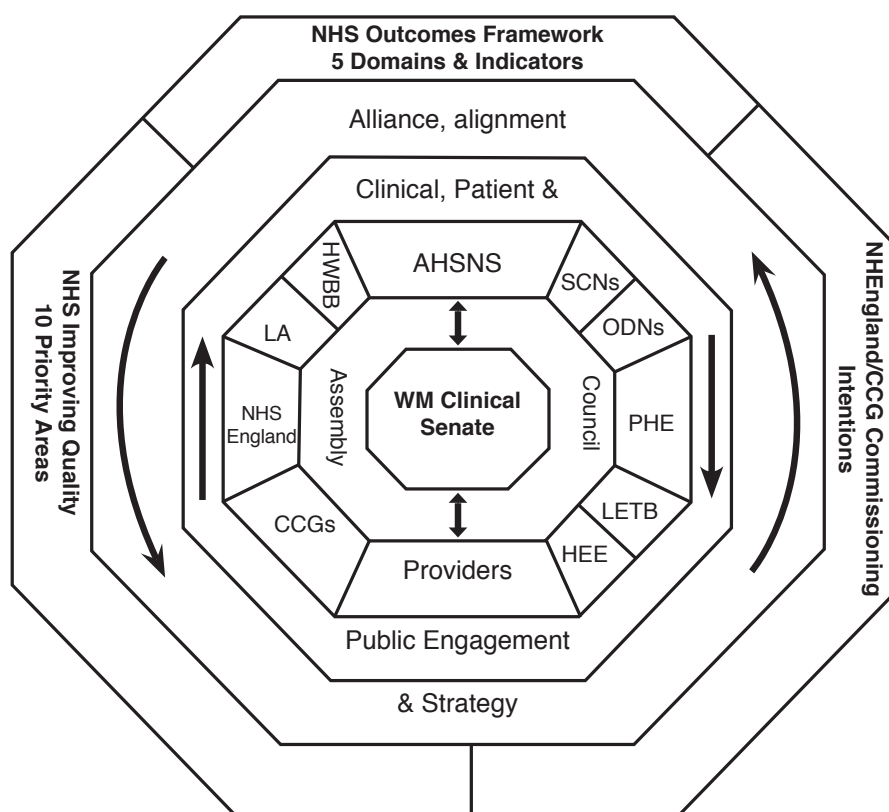
- 1) It is important as clinicians to bear witness to the changes in the NHS that are happening. We may not agree with the changes, but we can do our utmost to make them less painful and, in effect, 'less awful'.
- 2) Given the labyrinthine structures described, there is a very real risk of our patients falling between all these different bodies and missing out on treatment. It is hence crucial that there are specialists on all of these bodies, whether CRGs, SCNs or Clinical Senates making the case for their patients either with their CCGs or with NHS England.
- 3) Where aspects of commissioning arrangements are proving unsuccessful, it is vital that we use organisations such as the NHSCA, Royal Colleges and others to highlight these issues directly with government.

It is very clear that it is going to be a very rocky road. In June, Monitor announced the first legal challenge to the commissioning arrangements when BMI Healthcare complained about the commissioning arrangements for radiosurgery for certain types of brain tumours. The only thing that is certain is a significant amount of money which could be devoted to NHS care will now have to be diverted into such legal challenges. So the next time you hear how there is no extra money for the NHS, just recall how the reforms brought about by the HSCA Act have cost over £1 billion, with over £400 million in staff redundancies- many of whom will have been reemployed in the new organisations.

Hopefully I am completely wrong and the new organisations will work swimmingly. In the meantime, I would urge all doctors to familiarise themselves with who their representatives are on these organizations. If you are really confused by the new NHS speak, there is a very helpful animation that the Kings Fund have developed to explain what it all means (<http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england>)

Oh to live in "interesting times" as a Chinese proverb once said.

Senate Relationships and Context



Oversight of full portfolio of specialised services. Will ensure the work of the programmes is consistent with the strategic aims of the NHS CB



Times Change, Principles Endure

Andrea Spyropoulos
President, Royal College of Nursing

Introduction

There is no doubt that the NHS since its inception, has been revered, loved and more recently scrutinised and criticised. The inception of the NHS was built on a set of principles that have stood the test of time. However recent commentary indicates that the NHS is under threat

"Through a mixture of defeatism, lazy thinking and in the case of some, malign intent. We are in danger of sleepwalking towards dismantling the NHS"¹

I agree with Jeremy Taylor there is such a danger but it is not inevitable. Clinicians have always been at the forefront of healthcare and they are in a unique position because not only do they know the problems, they invariably have the solutions. Despite the current issues, the answer is not more reports, navel gazing or analysis, it is action. Clinicians are not the problem, they are the solution and I would argue that only the people who deliver the service can make the correct changes. To create a culture of caring, the underpinning values have to be defined, refined and owned.

The NHS is now facing its biggest challenges since its inception, politicians and public alike are scrutinising and questioning what can be afforded. As we strive to constantly achieve more for less the amount of paper work seems insurmountable. Despite the growth in management, the increased regulation, authorisation, business planning and the auditing, we seem to be failing. The constant reviewing, reorganisation and merging of services only seems to add to the problems.

As a nurse of 38 years I have seen unprecedented change not only in my own profession but in the NHS and indeed in society as a whole. I have never lusted for bygone days, nursing has made huge advances and I am very proud of our nursing staff and I am grateful for the dedication and commitment they still show. Indeed my early days in nursing were pretty scary for both

me and the patients so we have come a long way. Modern nurses have to be compassionate and caring but also have to achieve high standards and they require an education to meet the requirements placed on them in the modern workplace. Advanced practice is welcomed and patients have benefited, however during that development period we have neglected a key role, that of the ward manager. It used to be the plum role for aspiring nurses, it was a role that was universally respected and everyone understands the importance of having the best of nursing in this key role. It is now one of the most challenging roles in nursing.

As a ward sister I felt I had absolute authority to control standards not only of the nurses but also the doctors and allied health professionals who entered my domain. Of course there was a line of authority to the Manager above me who was always a nurse and the manager above her The Matron and lately the Director of Nursing, so there were always checks and balances. However once you were appointed as a Ward sister / manager there was an expectation that you would manage, you were ultimately accountable along with the consultant for the care and treatment of the patient. You were trusted to make sensible decisions and your professional skills were recognised and respected. Ward sisters had confidence, commitment, pride and passion in abundance.

The focus as it is now was always on the patient and the senior nurses worked hand in glove with the senior doctors. I never felt I could not speak out and I never experienced the enormous pressure of meeting targets dictated from afar. I did have pressures but they were from within the work place to be the best, to deliver the best care and there was pride and enjoyment in serving patients' needs.

The erosion of the Ward Sister/Charge Nurse role has made the modern day equivalent a tough job; it is highly pressured and the obsession with showing a saving on a balance sheet has meant

that the Ward Sister invariably was required to take direct responsibility for the intimate care of patients and to carry out the other duties, teaching, mentoring, management, collaboration standard setting and budget control as well. The external control over their day to day work has meant they spend more and more time in reporting and planning than nursing.

There is a persistent message coming from all areas of nursing but also identified in recent reports that there are just not enough nurses to deliver the standard of care the public expects and deserves. Staffing levels have been a real cause for concern in many of the failing hospitals highlighted by the very recent Francis report. Nurses themselves are identifying the core issues and they show real concern regarding their inability to complete nursing tasks they consider essential because of time pressures. A recent survey undertaken independently but on behalf of the RCN makes startling reading. The nurses were asked to identify tasks that needed to be done but they failed to do on their last shift.

The table below shows the outcome of the survey

Activity	Percentage of nurses reporting that this aspect of care was left undone, or was done inadequately on their last shift due to lack of time
Helping patients use the toilet or manage incontinence	33%
Prepare patients and families for discharge	30%
Skin Care	30%
Pain Management	19%
Care of dying patients	17%
Comforting/talking to patients	78%
Promoting Mobility and self care	59%
Oral Hygiene	48%
Falls Prevention	45%
Sufficient change of patients' position	41%
Information giving to patients and family	38%
Helping patients with food or drink	34%

The nurses identified not having enough time as the reason. These tasks were all things which they desperately wanted to do. So as Francis has said we need to change the culture. To do this we have to define our values, as they dictate behaviour and value is not about money. It is about having a system that supports good practice by giving clinicians the freedom to do the right thing. It defines what we will stand for and what we will not. We have to create a culture of ownership, where drive, passion, commitment and competence come from individuals who strive to be the best and to do their best. They have to take pride in their work and they have to have a sense of belonging, this is a culture of ownership. Culture change will not happen with more of the same.

Understanding 'value'

The £13 million spent on the Francis public enquiry would have purchased a small army of nurses. The shift to a finance business driven health system needs to change. Financial probity and balancing of the books is not the same as a profit driven economy. The critical role of the Ward Sister/Charge Nurse has to be reignited, recognised and rewarded; they must be supervisory, highly skilled and competent. They must always remain the hub between the service and the patient.

There are glimpses of hope. Some Senior Nurses are trailblazing change; wearing a nurse's uniform when on duty, with Chief Nurse emblazoned proudly on the uniform. This is a sign of maturity in the profession. Wearing the uniform (instead of a suit) sets them apart from other managers but for all the right reasons. It reflects the importance of nursing in the board room, and places them and nursing on an equal footing with the rest of the board. What is really exciting is that it sends a clear message to patients, that the senior nurses are there for them.

These senior nurses display all of the characteristics of a culture of ownership. Commitment, Engagement, Passion, Initiative, Stewardship, Belonging, Fellowship, and Pride. In recent times we have allowed financial targets to take the lead in defining our health care system. When we talk about 'value', we invariably talk about value for money. When we talk about 'efficient' and 'effective' we often mean cheap. In a culture of ownership we do the right thing for the patient; we prioritise care and compassion. We take a holistic approach to care planning, with the patient at the centre of what we do. If we get this right we will have an effective, efficient system not because it is the cheapest, but because it is the highest quality. We start with striving for the highest quality and, in the end, quality care is cheaper because outcomes are better.

If we really want a culture change we have to ask key questions. We all think we know what good quality care looks like, based on standards that are regulated, but regulation has not prevented the unacceptable situations we have seen in numerous reports. We need to include measures that tell us not only what good looks like but

what it feels like for the patients and the staff.
In your workplace, is quality talked about or delivered?

What is the prevailing culture, cost containment or quality?

When we talk about transformation, is it linked with cost cutting or is it genuinely an attempt to improve quality? It may well do both, but the underpinning value will influence the behaviour and subsequently the success or failure of the project.

On the Hubert Humphries Building in Washington there is an inscription:

"The moral test of government is how we treat those who are in the dawn of life, the children. Those who are in the twilight of life, the aged and those in the shadows of life, the sick, the needy and the handicapped".

The health system we have largely meets this test; its continuity is reliant on politicians and the nation for constant support. The role of the clinician is to strive for continued improvement, to respond to change and challenge, as they have done on numerous occasions. The only people who can improve care, are those who deliver it. It is time for action. Doctors and Nurses have to unite to get it right.

Who can change the culture?

The answer is you, politicians or reports will not deliver this change it has to come from the individuals in the system taking control of the system. Every individual has an opportunity to make the change. It is time for Doctors, Nurses and allied health professionals and the public to stand up and be counted and to jointly fight for the health service we hold so dear. Every decision we make regarding the health system should be premised by "remember the patient in this". Defining the underpinning value system is critical. This will create an environment that cultivates pride and passion in the workplace which will benefit everyone; public, patients and professionals.

My plea to our politicians is help those who help others. Give us the freedom to deliver the cultural change so badly needed. My plea to the medical and nursing professions is respect each other, stand together and take control of the health system back into your hands, for the benefit of the patient.

- 1 65 views of the NHS at 65: The Wisdom of the Crowd edited by Nicholas Timmins 2013 Nuffield Trust Jeremy Taylor page 207 available for download. www.nuffieldtrust.org.uk/publications

The NHS in Wales

O bydded i'r hen wasanaeth barhau*

Cathy White
Paediatric Neurology, Swansea

"Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community."

Aneurin Bevan

Wales has many of the same health problems as England – a rising number of older people, many frail; increasing demands on already overstretched GPs and A+ E services; high

hospital bed occupancy rates and continuing health inequalities.

In some cases things are worse – more of the population are obese (57% of the population of Wales is overweight or obese) and levels of chronic illness in Wales are higher than in England (one third of all Welsh adults have at least one chronic condition) and we have, and will have, to contend with even bigger percentage budget reductions

than in England. We are more dependent on the public sector for jobs and Westminster's public spending cuts hit Wales disproportionately hard. We struggle to fill trainee posts in some areas of Wales. Yet the way Wales has gone about trying to address these problems contrast starkly with what is happening in England and are taking the provision of healthcare along a strikingly different path.

Most of us living and working in Wales look at what is happening to the NHS over the border with increasing horror.

The changes that have occurred in Wales have been a direct result of decisions made in 2008 by the then Health Minister Edwina Hart. She clearly stated her expectations to a body she set up – the Bevan Commission, and her actions have not belied her words.

"I believe in the principles set out by Aneurin Bevan. Many things change but principles do not. I want the NHS to remain loyal to the principles established by Nye Bevan. I want you to advise me how to achieve this within the reformed NHS."

In the same year she formally ended the purchaser-provider split, rejected private sector involvement in Wales NHS, and confirmed forward planning of healthcare as an integrated whole, rather than leaving market demand to determine priorities. Such has been the commitment to using only public and voluntary sector organisations that a new NHS IVF facility has been commissioned and built taking over from an established and very successful private provider in South West Wales.

This consensus has not been challenged by the two Health Ministers who have followed her.

To begin to achieve this the NHS in Wales underwent major change in October 2009 in the words of the politicians "to equip it to deliver better healthcare to the population of Wales in the 21st century". Specific objectives also included

1. ensuring that the NHS delivers care effectively with its partners; specifically providing more joined up services between health and social care.
2. providing more care closer to people's homes.

3. more self-care programmes to help people live more independent lives.
4. an increasing focus on public health, creating a wellness service, rather than a sickness service.

It explicitly meant to shift the balance of care, looking at whole systems rather than just hospitals.

This created single local health organisations that are responsible for delivering all healthcare services within a geographical area, rather than the Trust (usually hospital provider) and Local Health Board (purchaser) system that existed previously. The NHS now delivers services through seven Health Boards and three NHS Trusts in Wales.¹

The Structure of the NHS in Wales

The seven Local Health Boards (LHBs) in Wales now plan, secure and deliver healthcare services in their areas, replacing the previous twenty two LHBs and 7 NHS Trusts which together performed these functions in the past. The names of some of these have provoked adverse comment ("How would you know where they are?") but using the name of the founder of the NHS for the health board that covers his old constituency is, perhaps, a very public statement of intent to remain true to the ideals of the architect of the NHS and Hywel Dda (King Hywel the Good), who is probably unknown to most across the border, produced a codification of Welsh law in the 10th century that is still renowned for its compassion and common sense; as well its recognition of the rights of women.

The three NHS Trusts have an all Wales focus. NHS Direct has been retained as part of the Ambulance Service and is still nurse led.

Health Boards in Wales

Aneurin Bevan Health Board
Abertawe Bro Morgannwg University Health Board
Cardiff and Vale University Health Board
Hywel Dda Health Board
Cwm Taf Health Board
Betsi Cadwaladr University Health Board
Powys Teaching Health Board

NHS Trusts

Welsh Ambulance Service Trust – for emergency services

Velindre NHS Trust – specialist cancer care
Public Health Wales

Community Health Councils were retained, although their numbers were reduced to seven contiguous with the new Local Health Boards. These statutory lay bodies still represent the interests of the public in the health service in their district and provide people with an independent voice in their local NHS and the services it provides.

The internal market and the purchaser provider split were recognised to have had ‘unintended’ consequences and their abolition was intended to deliver a number of benefits.²

1. **Strengthening partnership working** not only between different parts of the health service but also with other bodies.
2. **Providing a balanced attention to different parts of the health system** – trying to take the focus off acute hospital activity, in short.
3. **Bringing together service planners and the caring professionals** - ensuring plans are well informed by relevant professional expertise and offer ongoing encouragement to professional staff to strive for continuous improvement.
4. **Reducing public confusion over roles** – making who does what clearer to the ‘man in the street’.
5. **Changing the language to emphasise clinical quality and outcomes** – not counting numbers of patients seen or operations done.
6. **Better overall cost control** - the internal market was expected to reduce costs but overspends were the norm and making efficiency savings difficult, if not impossible.

In 2011 the independent advisory body the Bevan Commission (which included as one of its members Dr Donald M Berwick KBE, President Obama’s Administrator of the Centers for Medicare and Medicaid Services) reported that these reforms had gone some way to improving integration within the service and with social care and had embedded improving quality and

were keeping to Bevan’s principles. They also identified various threats including increasing costs but felt that the system afforded effective mechanisms for cost control. Involving the public in improving their own health and changing their expectations about what can be achieved and where was another target for the next five years. It explicitly rejects rationing as a way forward but recognises Wales faces a funding gap of between £1.3 and £1.9 billion by 2014-15.³

This is not to say everything in Wales is going well. Ann Clwyd’s husband died in the University Hospital of Wales having endured appalling lack of care. Critics in Wales and England point to our inability to hit various targets including the ambulance response times and that increasing numbers of people are waiting more than 26 weeks for treatment.

A public consultation in South Wales has just finished that will reduce the number of hospitals providing certain services (A+E, paediatrics, obstetrics and trauma care) for 24hrs a day 7 days a week. This has been done following extensive professional engagement to determine which options to lay before the public. The end result will not please everyone but no-one will be in any doubt about why this needs to happen and although there have been protest groups campaigning against local reorganisation plans the changes will happen.

In summary, unlike the NHS in England, NHS Wales is avoiding the marketplace and competition in favour of an integrated system, where the assets of the health service in Wales are owned by its government and its people. Whether this will be enough is for us in Wales to prove.

References

- 1 NHS in Wales: Why we are changing the structure. Welsh Assembly Government October 2009
- 2 <http://wales.gov.uk/consultations/healthsocialcare/nhswales/?status=closed&lang=en>
- 3 2008 – 2011 NHS Wales: Forging a better future A report by the Bevan Commission 2008 - 2011

* The last line of the chorus of the Welsh National Anthem is ‘O bydded i’r hen iaith barhau’, which means ‘O may the old language survive’. The old language being Welsh, which is still used throughout the country. Gwasanaeth (mutated here to wasanaeth) means service.

We need a citizen's coalition to save the NHS

John R Ashton

NHS SOS: How the NHS Was Betrayed and How We Can Save It

Jacky Davis, Raymond Tallis

Oneworld, 2013288

Foreword by Ken Loach. £8.99

ISBN-9781780743288

I owe my life to the UK's National Health Service (NHS) but not in the usual sense. My father was one of the early patients with type 1 diabetes whose life was saved by insulin. He had left school when he was aged 14 years and worked as an office boy in a brewery in Liverpool. In 1942, along with thousands of others, he queued to buy a copy of the Beveridge Report from Her Majesty's Stationery Office—it had sold out by lunchtime. Emboldened by the advent of the NHS that would provide treatment for my father's diabetes, and as good citizens responding to the call to "replace the war dead", my parents decided to increase their family. I am the youngest. Three of the four of us have spent our working lives in the NHS as passionate believers in this precious symbol of social solidarity. And now it is on the verge of destruction by carpet baggers and chancers imbued with the values of the free market, of a naked ideology free of the impulse that led to the establishment of the NHS on July 5, 1948.

In NHS SOS Jacky Davis and Raymond Tallis have brought together a sort of "hot history" that documents recent destructive reforms to the NHS, with contributions by some of the key protagonists of this treasured institution who have opposed the malign intents of the UK's Coalition Government, notably former Secretary of State for Health Andrew Lansley. It is an ugly story with a large cast of people who should hang their heads in shame. As Ken Loach states in the foreword to this important document of record, "The reform of the National Health Service is, of course, to bring it back to the marketplace and degrade it back into making health care a commodity—so it's not a reform at all".

What I find remarkable about the events of the past 3 years in the UK is the way in which the atomisation and unravelling of the NHS has taken place with so little scrutiny by those such as the BBC and trusted news media to which many people look to keep us informed as citizens and to protect our democracy from those who would hijack it for their own ends.

The creation of the NHS itself came about as a result of a unique confluence of events. My grandfather's generation, who had experienced the hardships of the Great Depression and the rise of fascism in interwar years, made common cause with my father's generation, who were returning from the fronts and fields of World War 2, determined to give the next generation a secure future, free from the fear of economic insecurity and conflict. The great institutions of the UN, including WHO, were part of these "organised efforts of society" with public health measures that looked upstream and tackled William Beveridge's five giants of Want, Ignorance, Idleness, Squalor, and Disease on an awesome scale.

The creation of the wartime medical service in the UK had brought together the voluntary, university, and poor law hospitals in a unified way to respond to the medical needs of casualties from the field and Blitz alike—an initiative impossible in the class-ridden Britain of the prewar years. Growing out of the necessity of "wartime socialism", Aneurin Bevan's vision of equal access for equal need, free at the time of use drove this ambitious social project. The appalling inequalities of health-care provision that had existed between the different hospital types before the war were to be a thing of the past.

But now that project is in danger. NHS SOS gives a triangulated blow-by-blow account of the cynical destruction of the NHS by ideologues, gullible fools, and those whose motives are known only to themselves—but are likely to have included large measures of

unenlightened self-interest. For me the notion of active citizenship, which was imbued in me as a child, flows through these pages: from the outrage of Tallis and Davis, whose initiative it was to bring these combatants for public health and wellbeing together, to the detail of each contribution that underlines the legacy of Bevan that “The NHS will last as long as there are folk left with the faith to fight for it”. The book offers a courageous and persuasive defence of the NHS by people who without fear or favour have spent the past 3 years fighting for our inheritance and that of those who will come after.

This book should be read by all those who love the NHS and wish to try at this late hour to protect it. NHS SOS details the lies, the bad faith, the limp and the supine, and the almost total failure of leadership by the medical establishment, the political establishment of all parties, and the trades unions—with a few notable exceptions. The mysterious failure of the media to do its duty has already been mentioned, but the malicious influence of ministerial special advisers seems to have played an important part here. Chapter titles such as “Breaking the Public Trust”, “Ready for Market”, “The Silence of the Lambs”, and “A Failure of Politics” capture the ground covered. Within them is chronicled chapter and verse of a betrayal that is reminiscent of the Last Supper but this time with a multitude of Judases claiming to act in good faith whilst cynically manipulating public and parliamentary opinion. In my view the behaviour of Shirley Williams in supporting the Coalition Government’s reforms of the NHS will surely be her legacy and eclipse her previously important contributions to public life.

As for Lansley, the architect of this crime and tragedy, his refusal to participate in a proper democratic process and denial of the spirit of British democracy right down to the wire, with his refusal to publish the assessments of risk inherent in his legislation while the private sector drooled in the wings, is documented in this book. The question remains, “why was the profession [of medicine] so badly let down by the leadership, none of whom has so far expressed any remorse?”

In an afterword “What You Can Do to Save the NHS”, Davis and Tallis identify the key lessons of this dreadful saga and have a first shot at a strategy to save the NHS. One thing is clear to me: the experience not only of the past 3 years but of the past 30 years, when successive governments have softened up the NHS for privatisation, means that the NHS is not safe in the hands of any current political party. Only a broad coalition of active citizens can recreate the consensus of 1948 around a refreshed vision of an NHS rooted in public health that provides equal access for equal need free at the time of use. This refreshed vision of the NHS is for a 21st-century demographic that has high expectations of health care within a context of a plethora of interventions to protect and improve health and maintain wellbeing in the face of long-term conditions. It will require real leadership to re-engineer the NHS in partnership with the citizens of the country. I believe that the flirtation and collusion with the private sector will turn out to have been an expensive mirage pursued by politicians who are unable to provide proper transformational leadership. Davis, Tallis, and the authors of this timely book can look the memory of the visionaries of 1948 in the face, unlike the many guilty described in its pages.

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Editor

While I agree with the drift of David Levy’s trenchant piece about the Francis report, it is unfortunate that he casually included Schwarz rounds in his list of “sexy new interpersonal techniques, mostly unproved”. I am not involved in this project, but we can easily find support for the effectiveness of Schwartz Rounds, for example in Lown et al, 2010 and Goodrich 2012.

yours faithfully

Sebastian Kraemer

NHS Scotland v England

Co-operation v Competition

Matthew G. Dunnigan

Summary: The introduction of increased competition, choice and privatisation to the English NHS from 2000 and the retention of a public sector model of healthcare in Scotland after devolution inadvertently provided a case-control study of the relative effectiveness of a neoliberal model of healthcare. Discounting the confounding effects of PBR – associated gaming on trends in English hospitalisation rates, comparisons of a range of outcome variables showed similar large improvements in the response to demand for emergency and elective healthcare between 1998-99 and 2010-11 in both countries. Analysis of trends in hospitalisation rates for a range of specific elective surgical procedures showed no statistically significant advantages from implementation of neoliberal healthcare policies in England compared with its Scottish public sector counterpart. In both countries improvements resulted principally from unprecedentedly large increases in capital and revenue expenditure between 1998-99 and 2010-11. Regrettably, the neoliberal policies implemented by New Labour facilitated the more radical fragmentation and privatisation of the English NHS incorporated in the provisions of the Health & Social Care Act in 2012.

At your editor's suggestion, I am updating previous accounts of the performance of the "modernised" English NHS compared with its unreformed post-devolution Scottish counterpart which appeared in the June 2011 and June 2012 Newsletters.

The last two decades of the twentieth century were periods of rapid growth in NHS clinical activity in the Scottish and English health economies. Between 1985-86 and 1995-98, inpatient and day case hospitalisation rates per 1000 population in England and Scotland increased by 36% and 45% respectively, emergency inpatient admission rates increased by 51% and 46%, new A&E attendances increased by 17% and 28% and new outpatient attendances by 27% and 23%. These increases were accompanied by declining staffed bed numbers, lengthening waiting lists and waiting times and regular winter bed crises. There was a widespread view that the NHS was failing and unfit for purpose.

In 1998-99, following devolution in Scotland and Wales, health became a devolved matter in both countries. In 2000, the UK Labour administration implemented a large increase in funding which transformed the performance of the NHS. Between 1998-99 and 2010-11 per capita NHS funding in England and Scotland increased by 98% and 78% respectively in real terms. In both countries waiting lists and waiting times fell rapidly in the next decade, facilitated by investment in waiting time initiatives, acute admission units, 24 hour wards and substantial increases in medical and nurse staffing. Winter bed and waiting times crises subsided, there were substantial reductions in mortality rates over a wide range of conditions and public approval ratings for the NHS soared. In the midst of the current severe austerity for the public sector in general and the NHS in particular, it is worth recalling the success of Labour's financial policy which renewed a previously underfunded NHS.

In England, however, the Blair government insisted that the price of increased NHS investment was "reform". This involved the extension of the internal market in healthcare to provide more choice, competition and privatisation. Hospital autonomy was encouraged by the creation of self-governing Foundation Trusts and Payment by Results (PBR) in which a hospital's financial viability depended on its case-load for up to 60% of its income via a complex tariff system.

In Scotland, the Labour administration followed a different course. The Thatcher-inspired reforms of the internal market had been only nominally implemented with little discernible effect on the structure or funding of secondary healthcare. Few GP practices in Scotland adopted fundholding. Following devolution, the Scottish Health Executive introduced a new policy strategy based on the creation of Managed Clinical Networks for major specialties. These promoted cooperation and integration between the primary and secondary healthcare sectors and between hospitals, Health Board funding from block grants continued based on a long-standing funding formula based on variables such as population size and age-structure,

and on indices of deprivation and standardised mortality which determine morbidity rates. Hospital case-loads were not a variable in the funding formula. In 2003, the internal market was formally abandoned.

Labour Health policy was continued by subsequent SNP administrations which ended the privatisation of clinical services and the proposed closures of smaller hospitals, A&E and maternity units in remote areas of Scotland. Further integration of NHS and community care was facilitated by the SNP's provision of free personal care for the elderly and by the Scottish Health Department's "Restoring the Balance" policy which encourages the transfer of secondary care to the primary and community care sectors.

The introduction of a new neoliberal model of healthcare by the Thatcher administration ended the more benign preceding era of consensus NHS management in 1984 in favour of general management (the Griffiths Report). Unfortunately, this erosion of professional autonomy has continued in Scotland, with negative effects on consultant morale and self-esteem. Nor has the Scottish NHS avoided the infliction of PFI, the privatisation of non-clinical hospital services, the organisational problems associated with the European Working Time Directive (EWTD) for hospital medical staff, or the byzantine complexity of the Quality and Outcomes Framework (QOF) contract for general practitioners.

As a result of these differences in health policy, striking trend differences in hospitalisation rates emerged between Scotland and England in the twelve years after devolution between 1998-99 and 2010-11. Hospitalisation rates for inpatient and day case discharges in all specialties rose in England by 27%, but fell in Scotland by 2%. Emergency inpatient hospitalisation rates in England rose by 30% and by only 11% in Scotland, new A&E attendances rose by 52% in England and by only 13% in Scotland and new outpatient attendances rose by 35% in England and by only 4% in Scotland. These large differences in apparent crude productivity between Scotland and England following devolution attracted very unfavourable comment from the Nuffield Trust in its 2010 review of the performance of the Health Services of the four countries of the UK.

In reviewing these trends, I was struck by the counterintuitive thought that, when combined

with rapid declines in waiting lists, waiting times, delayed hospital discharges, compliance with A&E waiting time targets and the disappearance of winter bed crises, the flat trends in hospitalisation rates in Scotland might indicate a broad equilibrium between supply and demand in the secondary healthcare sector. This hypothesis did not fit with the neoliberal obsession with continuing growth and increasing productivity but was consistent with Scottish post-devolution hospitalisation rate stability in which demand for elective and emergency care was met. Scottish GP consultation rates, accounting for over 80% of all doctor patient face-to-face consultations, also changed little between 1990-91 and 2010-11. The trends were also consistent with the Scottish Health Department's emphasis on integration and cooperation between the primary, secondary and community care sectors, leading to reduced pressure on the hospital sector.

The large increases in hospitalisation rates in the English NHS between 1998-99 to 2010-11 may indicate a component of unmet demand, but interpretation is complicated by evidence of perverse incentives to increase recorded hospital case-load associated with the central role of PBR in determining hospital income. For example, the rising trend in hospitalisation rates between 1998-99 and 2010-11 was non-linear, with only small increases in rates between 1998-99 and 2003-04, accelerating rapidly between 2003-04 and 2010-11. The latter period was associated with the introduction of PBR and Foundation Hospitals. Further deconstruction of the PBR-related mechanisms underlying these increases is outside the scope of the present contribution.

In order to provide more accurate comparisons between Scottish and English elective hospitalisation rates following devolution, it is necessary to examine treatment rates for well-defined specific procedures. The Nuffield Trust study provided hospitalisation rates for six elective surgical procedures in the four countries of the UK in 1996-97, 2002-03 and 2005-06, and the Office of National Statistics (ONS) similarly examined hospitalisation rates for nine elective surgical procedures in the five year period 2005-06 to 2009-10. Statistical analysis of pooled hospitalisation rates for these procedures over this fourteen year period indicates that Scottish rates remained significantly higher than English rates in 1996-97 and 2005-06 in the Nuffield Study and in 2005-06 and 2006-07 in the ONS study. In the three

final years (2007-08, 2008-09 and 2009-10) English and Scottish hospitalisation rates plateaued as previously unmet demand was satisfied and were not significantly different. The marked difference between this data and the large differences in trends and hospitalisation rates between England and Scotland created by PBR-related perverse incentives is striking.

Trends in Standardised Mortality Rates (SMR) provide indicators of the success or failure of public health preventive policies and treatment outcomes. Scotland's SMR remains about 20% above England's reflecting higher levels of deprivation, smoking, alcohol consumption and unexplained factors. Nevertheless, between 1999 and 2010, all cause SMR in both England and Scotland fell by 45%, circulatory disease mortality fell by 59% in England and 62% in Scotland, respiratory disease mortality fell by 61% in England and 57% in Scotland and cancer mortality fell by 32% in both England and Scotland.

Hospital Standardised Mortality Rates (HSMR) provide a useful indication of hospital safety, although data interpretation has many caveats because of multiple confounding variables. HSMR trends for all Scottish acute hospitals are publicly available for five years between October 2007 and September 2012. In this five year period, regression analysis indicates a highly significant 12% decline in HSMR rates. An attempt by the author to obtain all-England HSMR trends from Dr Foster Intelligence ended in failure when an offer to provide the data was finally made (and declined) at a cost of £3,000 plus VAT!

In 2011, Scottish per capita healthcare funding was 8% above the NHS average for England (£2,089 v £1,932). Despite this relatively small difference, in 2010-11 Scotland employed 26% more doctors per 1000 population than England (3.4 v 2.7 per 1000) and 25% more GP's (0.94 v 0.75 per 1000). Scotland also had 75% more staffed beds in all specialties (4.7 v 2.7 per 1000) and 52% more acute beds (3.2 v 2.1 per 1000) than England. In consequence, post-devolution pressures on Scottish medical and nursing staff have been less with significantly lower average occupancy levels and longer mean lengths of stay. The reasons for these discrepancies between relative NHS funding, staffing and bed provision are uncertain, and merit further investigation. The costs of continuous reorganisation, privatisation and multiple PFI initiatives for the twenty first century English NHS appear possible candidates.

The severe cuts in public sector and NHS spending initiated by the coalition government have equally affected Scottish NHS funding. Referral to Treatment waiting time targets continue to be met, the number of delayed discharges from acute hospital beds remains low and HSMR rates have declined, as noted above. However, the Scottish NHS was shaken in 2012 by evidence of widespread covert transfers of patients from active to deferred waiting lists because of pressure to fulfil waiting time targets with reduced funding. This led to an Inquiry by Audit Scotland and the sacking of the General Manager of Lothian Health Board "pour encourager les autres". While less severe than in England, rising pressure on A&E departments, exacerbated by a severe outbreak of winter vomiting across Scotland in the winter of 2012-13 led to frequent breaches of four-hour A&E waiting time targets while average occupancy levels of 85.4% in the first quarter of 2012-13 resulted in severe pressure on bed capacity, nursing and medical staff.

What has not emerged in Scotland up to now have been major scandals in patient care such as mid-Staffordshire (high inpatient death rates), Morecambe Bay Foundation Trust (high perinatal mortality rates), Winterbourne View Care Home (ill-treatment of learning disability patients), and NHS111 (privatisation and untrained "healthcare advisors"). As in England, Scotland has a range of health monitoring bodies, HSMR rates are closely scrutinised and an active media is alert to potential health scandals. While the absence of these in Scotland may simply reflect the reduced probability of gross malpractice in a smaller patient population, it also seems plausible that the perpetual reorganisation inflicted on the English NHS since 2000, and the desire of Hospital Managers to attain Foundation Trust status at all costs led to poor oversight of standards of care and the suppression of whistle-blowers, in contrast to relative organisational stability in Scotland.

Finally, the Scottish population owe a debt of gratitude to the little-known Old Labour Scottish politicians in the devolved parliament in Edinburgh who resisted the chimerical promise of market-led NHS reform inflicted on England by their New Labour colleagues. How they achieved this remains an untold story.

Unwinding the NHS downward spiral

Is the public involvement in healthcare decisions a deliberate political deception?

Mark Aitken

The public has been involved in healthcare decisions for decades. Complaints, which have entered the public domain, have been the main catalyst for healthcare providers to improve service delivery. Recent deliberate strategies of asking the public to comment on healthcare services might be seen as a better way of avoiding poor quality, but do the providers and commissioners of healthcare really bother to take any notice of the public desires and aspirations uncovered by this process?

Foundation Hospital Trusts (FHTs) and Clinical Commissioning Groups (CCGs) are both legally bound to demonstrate their active engagement with the public they represent. In the case of FHTs this is achieved through meetings with their elected public Governors. In Colchester the CCG consults with its public through their elected Health Forum Committee (HFC).

Qualifications for being a public representative.

Public representatives are assumed to have had personal or family experiences as a patient. In the vast majority of cases these representatives have no medical, nursing or other healthcare training. This puts them at a serious disadvantage if they are expected to make a meaningful contribution to the planning or auditing of healthcare activity.

The cost of providing this public scrutiny.

Public representatives provide their services free. The only payments they receive are for the reimbursement of travelling expenses. One might imagine therefore that the cost to FHTs and CCGs would be similar. However, Colchester's FHT supports this service with an annual budget of about £100,000 (this excludes salaries for the secretariat), whereas the NE Essex CCG HFC has a budget of about £10,000.

How do these different bodies engage with the public?

The Colchester FHT gives regular presentations

by members of staff at public venues. These are not fact finding events but well-choreographed PR exercises.

The NE Essex CCG HFC runs two-monthly local engagement events. These events suss out public concerns with everything from ambulance response times to podiatry services. CCG staff report back at subsequent meetings in order to clarify concerns and demonstrate progress in critical areas that have been identified by the public.

How do these locally elected representatives influence healthcare?

In the case of FHTs the interaction with the Board of Management is by proxy and rarely involves governors sitting on decision making committees. Public Board meetings are typically full of carefully crafted codswallop with no opportunity for the public to challenge the FHT performance or ask questions. Governors are regularly fed with statistics ranging from MRSA rates to death rates, but without specialised knowledge they are handicapped in being less able to ask for more detailed information which could reveal meaningful answers to poor performance.

HFC members are involved in the decision making CCG committees and therefore can influence the way in which services are commissioned. Their lack of medical, nursing or other healthcare training can make their contributions less effective. Any member of the public is able to attend the monthly public board meetings and the public is given about 15 minutes to ask questions.

Differences between FHT Governors and HFC members.

FHT Governors are expected to be critical friends of the Board of Management, i.e. they support the actions taken by the Board and are

discouraged from challenging the decisions that have been made.

HFC members flag up criticisms made by the local community and are encouraged to challenge the decisions made by the CCG Board.

Does any of this matter?

FHT Governors

The FHT Governors in Colchester have regularly failed to challenge changes to the infrastructure which have lacked any clinical priority. Maybe Colchester is a special case, because it started its journey as a FHT with serious deficiencies in its infrastructure and a fundamentally fragmented emergency service. Governors were presented with a series of spurious “modernisation” plans, which ignored longstanding clinical priorities, as financial wizardry, and therefore accepted them unaware of their clinical handicaps. The role of FHT Governors in the Keogh Inquiry is unclear and hardly mentioned in his 61 page report. In Colchester the Governors were lulled into a false sense of security by a sequence of upbeat reports on how death rates were falling and how the adverse Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) were coming under control.

In this regard the role of FHT Governors needs to be drastically overhauled. At the present time they merely represent expensive window dressing.

CCG HFC members

It is too early to tell whether the public involvement in CCG decision-making is yet another white elephant. However, the initial signs in Colchester are encouraging.

Managers have been keen to tap into the knowledge base of its public representatives. The main handicap of these publically elected members is a lack of medical or nursing experience and expertise. One might argue that they are only there to ensure that public concerns are addressed. However, specific medical knowledge can help to steer an otherwise sterile argument towards a clinically logical and pragmatic conclusion.

Next in importance to the CCG Board is the Transformation and Delivery Committee (TDC). 50% of its voting membership is made up by

GPs. Currently I am the HFC representative. This is where the clinical arguments and the financial consequences of projects are thrashed out before they are either recommended to the Board or rejected. The working parties that feed into the TDC usually have public representatives.

Clearly the involvement of the local population in the decisions made by the CCG is both evident and proactive.

Other bodies involved in public participation.

Just when everyone is getting the hang of where they might fit into this communications maze we discover that Healthwatch (the successor to LINKS) also has its fingers in this complicated PR pie. Members of Healthwatch are appointed by local authorities. They cover geographic areas which include a number of separate CCGs and their associated populations. They report themes which reflect common concerns within their areas of influence to NHS England. It is difficult to know how they could help where local GP services require attention beyond the remit of their local CCG.

Then there are Patient Participation Groups (PPGs).

Conclusion

The government really needs to get to grips with the haphazard way in which FHT Governors are expected to hold their hospital managers to account. Further tinkering with the current legislation is pointless. There has to be a thorough rebranding of their terms of reference. Doing nothing is not an option.

So far, CCGs appear to have hit the bull’s-eye, at least as far as NE Essex is concerned. It may be that we represent a flagship organisation and other less proactive CCGs ought to take a leaf out of our book. These are early days, and keeping the NHS out of inappropriate private sector intervention is an on-going challenge.

Healthwatch and PPGs sit above and below the locally elected public HFC respectively. Their effectiveness in bringing about meaningful changes to healthcare delivery is yet to be established.

Commissioning – a wasteful process but we must get involved

Chris Bunker

What can we actually do to meet the challenges of 'austerity'; the reforms and Francis - the rapidly changing health landscape? Before these latter day crises Dermatology was already straining under burgeoning demand because of an ageing population and an explosion in skin cancer, comorbidities, drug reactions and psychological morbidity. A demand unmatched by the workforce: not enough properly trained specialists in the right places; inadequate Dermatology teaching and training in Medical Schools and in General Practice; disillusionment and low morale. Indeed, the specialty has been in crisis for some time.*

As a Consultant it would be easy to bury one's head in the sand and just treat the patient in front of you the best you can. But we cannot ignore the bigger picture and the timeless responsibilities of the physician. There are things we can do both individually and collectively to make a difference to the challenges we face and to make it possible to work with Government policy – no matter how much we might disagree with it – to ensure that patients do not suffer and services do not evaporate.

As President of the British Association of Dermatologists (BAD) I initiated some work by our Clinical Services Unit (CSU) to look at how all the recent (and past) changes have affected our Specialty. The results are not applicable to Dermatology alone. The BAD has had to tackle a number of egregious commissioning decisions that affect access to care for Dermatology patients requiring treatment from secondary and tertiary services. From these experiences we have drawn together some 'lessons to be learned' and produced a document that gives advice for Commissioners and Clinicians as well as recommendations on what we think should happen next.* Other specialities might look to their own Colleges and Associations to see if they offer a similar service to the BAD's CSU because we have enjoyed some successes

where our involvement has elicited a healthier dialogue and a re-think from Commissioners and Providers. Decisions about commissioning are frequently made in isolation by Commissioners and without suitable engagement with local clinicians and patients: often the longer term effects of destabilization and risk to secondary and tertiary care services are overlooked.

We want to see commissioning based on quality more than cost. So we must have meaningful comparable outcome measures, including those based on patients views (PROMs). I believe the BAD is ahead of the game in this regard.

As Consultants working within any specialty, it is important that we take part in the processes that will eventually have effects on us, our Departments and the services we offer our patients. One critical thing that we can all undertake is to communicate our values to all we work with. We must also be conscious that we all have a responsibility to ensure safe and effective care for our patients. I think we have a duty also to argue for equitable access. All this may mean tough conversations with management and Commissioners and sometimes with patients. If we do not have the budget to offer a service safely – should we offer it at all? This is the 'neurotic knot' we face given the twin challenges of Francis and 'austerity'.

Like other bodies the BAD is preparing a response to the Francis report and Robert Francis QC has been to our HQ Willan House to help us formulate this. Like other bodies the BAD has responded to the Care Quality Commission's 'New Start' proposals. Laudable honest intentions or political cynicism? Meretricious? How do you measure quality? There is a risk that a new wave of tick box targets is about to be created and we've seen the evils of these. Anyway, the consultation document proposes not one performance 'indicator' for Dermatology.

Inspectors and inspections? Who? How?
How much (£)?

Francis has been eloquent about leadership. As Consultants we should have strong, secure and respected leadership credentials. We must be diligent and vocal in highlighting to management, Commissioners, other health officials and parliamentarians, inadequacies in service provision and patient care. Dr Martin McShane (Director, Domain 2, NHS England) has told me that he believes in Consultants as system improvers. Well so do I. But we have to be consulted and listened to.

It is not all up to us though. There are a number of things that we must ask of the Department of Health (regardless of who is in Government) and NHS England. Critically we need the clarity in the language used around community, integration and local care. And quality. They must get to grips with data. Without the development of a long-term, joined-up approach to data recording, that

ensures data sets are fit for purpose and can be mapped to care pathways across all service settings, commissioning condign services will remain problematic. We want more honesty about competition and firm assurances about conflict of interest and financial audit; what external mechanisms are in place to audit the ~£60 billion heading the way of CCGs?

The real elephant in the room is the cost management. I qualified in 1981. Horrified by the growing cost of the NHS, Resource Allocation of the seventies was replaced during the eighties by cost control in the form of Griffiths General Management. This has been followed through the decades by reform after reform so that now we have a cost control management system that probably costs far more than the actual cost of the clinical activity. The expenditure is largely on salaries of non-clinical staff, not just in Trusts, but in the commissioning process and in regulation; just look at the number of QUANGOs with something to say about health. Austerity?

The following messages were emailed on 13th August to all NHSCA members for whom we have addresses.
Thanks to those who have already responded.

They are repeated here to inform the other members for whom we do not have email addresses (but who we hope will provide them soon).

KONP is planning to make contact with all individual Clinical Commissioning Groups, quite a task. We have been asked to help if we can by circulating our NHSCA members with the following request for information. If you have the name and contact details for the Chair and/or CEO of your local CCG could you send them to officepa@keepournhspublic.com

You are probably aware of the major **National Demonstration to be held in Manchester on**

Sunday 29th September – to coincide with the Tory Party Conference. The increasing threats to the future of the NHS will figure prominently. The event is being co-ordinated by The People's Assembly and full details, including transport being arranged, can be found on the website www.thepeoplesassembly.org.uk

Final coordinating details have not yet been finalized but it is suggested that NHSCA members interested in taking part contact us by email at nhsca@pop3.poptel.org.uk so that they can be advised on any specific NHSCA meeting point etc

The AGM and Conference 2013

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

*Invitations with details of the event and booking forms were posted
to all members on 21st August. If any have gone astray or been mislaid,
duplicates can be obtained via the address below.*