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# NHSCA

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EDITORIAL December 2011

## The Profit Motive

What is the profit motive? It is the intent to achieve monetary gain in a transaction or endeavour. I mention here particular problems of the profit motive that apply to the NHS: conflict of interest, fraud and low staff morale. The list is not exhaustive.

### **Conflict of interest**

In a free market economy profit is the ultimate purpose of a commercial enterprise. In contrast one might speak of “production for use” as against “production for profit”. In the health service in the context of “any willing provider”, the priority might be the quality of healthcare or profit for the shareholders of a private company. Making a profit is the sine qua non of healthcare companies; every care pathway is governed by it. Since the bulk of healthcare expenditure goes on staff salaries, profit margins are obviously lowered by employing highly trained, well paid staff in recommended numbers. For example, it is often the case that the workforce in the UK private home care sector is abysmally paid, is poorly qualified and has a high turnover (Pollock, 2004, page 183). Cost reductions achieved by outsourcing and the profits made by outsourcing companies, are largely made by paying workers less.

In the UK, the medical director of BUPA acknowledged that in a health care market “conflicts of interest are everywhere” (Leys and Player, 2011, page 137). At the level of the individual, a private patient has to be concerned whether a recommended treatment is necessary or should be as extensive as advised given that the more activity there is, the higher is the doctor’s fee. Nationwide, huge finance and management consultant firms with global reach advise both private health care companies and the Department of Health, and of course get paid by both. Leys and Player have documented how the most senior staff have moved between health care companies (UnitedHealth, Care UK, Spire Healthcare, General Healthcare Group, Kaiser Permanente, Circle.....) the gigantic finance and management companies (KPMG, McKinsey, Capita.....) and the

Department of Health. Everyone knows about Alan Milburn and Patricia Hewitt. After Alan Milburn resigned as Secretary of State for Health (to spend more time with his family), he became an advisor to Bridgepoint Capital, a firm heavily involved in financing private health care firms moving into the NHS. Its clients included Alliance Medical, Match Group, Medica and the Robinia Care Group. Patricia Hewitt cited personal reasons for retiring from frontline politics, and subsequently became a “special consultant” to the world’s largest chemists, Alliance Boots and a “special adviser” to the private equity company Cinven which paid £1.4 billion for BUPA’s UK hospital assets (since rebranded Spire Healthcare). Moving in the opposite direction Dr David Bennett, a former senior partner at McKinsey, became interim chief executive at Monitor in April 2010 and chairman of Monitor in March 2011.

The mutually beneficial relationships between News International, the Metropolitan Police and politicians are on a tiny scale in comparison.

### **Fraud**

The global health care industry includes notorious cases of health care fraud and such fraud is endemic in the US system (Pollock, 2004, page 13). According to the Health Policy Network the FBI estimated that in the years 1990 to 1995 health care fraud in the USA totalled no less than \$418 billion. Examples of such fraud were overcharging the government, upcoding, not rendering a service to insured individuals and not re-imbursing them. Huge fines have been levied by the US Department of Justice. Thus UnitedHealth in January 2009 agreed to pay \$50 million to settle a case brought by the New York attorney general for boosting profits by systematically reducing insurance repayments to patients, and in the same month paid \$350 million to settle actions for non-payment of benefits. In September 2010 the state of California sought \$9.9 billion from the company in fines for thousands of alleged legal violations which the company denied.

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The culture engendered by profit provides encourages “gaming” in the NHS’s “payment by results” procedures. If payment to one’s organisation depends, for example, on diagnosis, there is a strong incentive to allocate more severe diagnoses. If the funding for one’s hospital depends on a fast throughput of patients, the incentive is to admit as many patients as possible and discharge them quickly.

### **Low staff morale**

There seems to be an intrinsic difference between doing what one believes to be right and performance based on reward and this applies with particular emphasis to health care (Fleming, 2011). The assumption that staff in private health care might be motivated by the “bonus culture” (i.e. that better performance results from financial incentives) is false. In fact rewarding people for doing something tends to reduce intrinsic motivation, stop individuals taking responsibility and in the long run lead to inferior work (Fleming, 2011). Sharp practice arising from commercial competition has an adverse effect on relationships between individuals in the same organisation and generates tensions between organisations. This contrasts with a system based on trust and common purpose.

In the competitive market being promoted in the NHS, organisations will boom and bust with consequent job insecurity. Transfer of staff from a unit closed down to one awarded a tender has in the past (depending on type of job) been protected by TUPE, but marked service reconfiguration leads to different jobs being created and staff transfer is likely to be accompanied by lower pay, reduced pension arrangements and loss of other benefits. Setting up NHS Foundation Trusts as separate businesses provided the legal framework for the abandonment of national terms and conditions of service. The way to reduce costs and increase profit is, as mentioned above, to make do with fewer staff at a lower grade.

### **The international perspective**

The economic ideology that has shaped the USA and the European Union for decades is of privatisation, deregulation and awarding privilege to corporate power. In the UK this ideology has been applied to the civil service, in education and to the NHS.

An analysis of transnational corporations reveals that a relatively small group of companies, mainly banks, have disproportionate power over the world economy. Of 43,000 transnational companies, 1318 control 60% of global revenues, and a super-entity of 147 tightly knit companies controls 40% (Coghlan and MacKenzie, 2011). This concentration makes the whole network unstable, as the world learned in 2008. According to Wikipedia, KPMG is one of the largest professional services networks in the world and one of the Big Four auditors, along with Deloitte, Ernst & Young and PriceWaterhouseCooper. Its global headquarters is located in Amstelveen, Netherlands and it employs 138,000 people. Ernst and Young is a global organisation of member firms in more than 140 countries, with headquarters in London.

The health and social care bill currently before parliament continues the ideological attack on what was a successful and cost efficient public service. The Department of Health will impose its politics and the private health care companies and large city firms will make huge profits.

**MORRIS BERNADT**  
**Guest Editor**

*Coghlan, A. and MacKenzie, D. (2011) The hard core of power. New Scientist, 22 October 2011 issue, 8–9.*

*Fleming, F. (2011) The bonus myth. New Scientist, 9 April 2011 issue, 40-43.*

*Leys, C. and Player, S. (2011) The plot against the NHS. Merlin Press, Wales*

*Pollock, A. (2004) NHS plc. The privatisation of our health care. Verso, London.*

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# The AGM

**Minutes of the formal AGM have been sent to those who attended and to all EC members. They are available to any other member on request, electronically or in hard copy.**

**Reports from AGM and Conference appear below together with a list of members of the new Executive Committee and their contact details.**

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# NHSCA Co-Chairs Report 2011

This has been yet another busy year for the NHSCA, due mainly to the continuing need to fight the Health and Social Care Bill. Our activities have focussed on this, and we have continued to work with sister organisations (KONP and the NHS Support Federation) in a number of ways. We have also worked with other organisations opposed to the legislation, including the major health unions and 38 degrees.

The grass roots of the BMA have repeatedly expressed their opposition to the Bill, a fact which has unfortunately not been reflected at the highest level by the leadership. It has been very helpful to have 3 members of NHSCA on BMA Council and we encourage you to think of standing next year. Turn out is low and previous BMA experience is not needed! Please watch out for further information about the Council elections, nominations open on 5.1.12 and close on 10.2.12.

Members have spoken and written extensively about the dangers of the Bill. There have been a number of articles and letters from members in the national press and the BMJ, and the NHSCA has either initiated or signed up to open letters to leaders of the BMA and the Royal Colleges, which have received national coverage. We encourage everyone to continue to protest in writing about the Bill wherever and whenever possible. Public speakers are needed by KONP, please consider volunteering for this vital activity.

There have been formal and informal contacts with politicians who seem as yet impervious to the concerns of the profession (so much for medical leadership!) If you haven't already, please consider contacting your MP and the scheme to 'adopt a peer'. I understand that their lordships are more interested in professional opinion than MPs and are less likely to be 'whippable' on the legislation.

The other issue to exercise the profession has been the threat to pensions, although many do not seem to grasp the fact that if the NHS bill goes through and much NHS care is delivered by the private sector then national terms and conditions and national pensions such as we have enjoyed to date will be a thing of the past anyway.

We thank our outgoing co chair Chris Burns Cox for his enthusiasm and time, and we welcome Clive Peedell, scourge of the establishment and prolific writer of open letters, as his replacement. We thank Janet Porter for her work on the website and Mark Aitken for taking it over, which he has done with energy and great good humour. We thank Malila Noone and Jonathan Dare for taking care of the important administration tasks which have kept us in order and in the black financially. And finally and most importantly we thank our tireless president Peter Fisher, who keeps the entire show on the road.

**JACKY DAVIS & CLIVE PEEDELL**  
Co Chairs NHSCA

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## National Health Service Consultants' Association

**HONORARY TREASURER'S REPORT FOR THE AGM OF THE NHSCA**  
**Saturday 1st October 2011 - Bedern Hall, York**

In Honorary Treasurer terms this year has been marked by making sure there are enough funds to defend the NHS against the Cameron/ Lansley NHS privatisation White Paper and then Bill. The effect of that can be seen by our largest ever year on year deficit-vide infra. The President and I continue our "chasing up" of members failing to pay their annual subscription with varied success. This has been a slightly better year in terms of recruitment of new members, with the president near to reaching one of his long term aims in terms of membership numbers. Unfortunately the overall effect has been to only raise our Subscription Income by 2%. An unfair reflection on the amount of work and effort expended!

For the first time ever I am appearing for the third successive AGM to speak to the Accounts which means the President is relieved of this onerous duty yet again! He does, however, continue to keep the finances flowing during my long sojourns in France. The Auditor Mr. Bob McFadyen has, once more, kept our accounts in impeccable order as witnessed in his accompanying report, again produced against a tight schedule.

In overall terms the accounts show one major change in that this year we outspent our income by £3,195.85 after several years of slow accrual. This is consequent on our regular quarterly £1,500.00

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support to KONP, extra contributions to the NHS Fed and our commissioning of "Reshaping the NHS" Unless the AGM decides to change policy this expenditure level will continue.

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

1. The Conference/AGM income exceeded expenditure for the first ever time in 2010, that has contributed to our ability to combat the ConDems assault. It was due to two factors namely the "value for money" of the location and the generosity of some of our speakers in not claiming expenses. It is a factor in the Committee's decision to have the Meeting in the same venue this year.

2. The "Other Income" is due solely to donations from individual members for which we are most grateful.
3. All other items show a remarkable consistency. The apparent drop in our contributions to KONP is illusory; it is only a function of the precise date that payments were made in our financial year. George Osborne would be proud of the NHSCA Treasury Team's financial control.

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

**JONATHAN DARE**  
Honorary Treasurer, NHSCA

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## KONP Report

The steering group has met every month apart from August at the RMT offices. We are very grateful for this facility as accommodation in London is expensive. We have co-opted another two GPs to the steering group, Ron Singer president of MPU, now part of Unite and Brian Fisher President of Socialist Health Association.

### Personnel

Adeline O'Keefe works two days a week. We really need a fulltime person but our bid for more money from the Joseph Rowntree Reform Trust failed. Helen Cagnoni has been working one day a week on the administrative side. This summer Hannah Russell finished the updating of the database and Paul Lister, our volunteer webmaster, is writing the programmes to interrogate this so we can chase members for subscriptions. Peter Fisher and Harry Keen attend the SG committee regularly.

### Website

www.keepournhspublic.com. Paul Lister continues to maintain the website (free) and gives invaluable advice for which we are very grateful. This year he has added films and Steve Bell's cartoons. Our thanks to Tamasin Cave of Spinwatch, and Pete Cann and Anne-Marie Sweeney for allowing us to do this. We have continued to pay Anna Macfarlane in Dundee and Matt Shapiro in Leeds to trawl the press to update the website.

### The Health and Social Care Bill

The work this year has been dominated by this government legislation. These proposals if enacted would destroy the NHS so we worked hard to mobilize public opinion.

Once the Health and Social Care Bill was published in January 2011 we distributed a leaflet '10 reasons to kill the Bill' by John Lister electronically to all our branches. We printed 2500 of these, and recently 20,000 copies of a new postcard to send to Cameron. The seventh edition of the newspaper dealing with the Bill sold out and the eighth has just been printed. In the last four months we have sold over three times as many badges, postcards and leaflets as in the whole of 2010.

### Response to consultations

We sent in a response to the Listening exercise Shirley Murgraff of Hackney KONP (who has just done a video for You tube) and I managed to get to the London listening exercise held in Islington where, despite most of those present being voluntary sector people, the Bill was roundly condemned. We also, with Janet Shapiro went to the Guardian event, where Steve Field answered questions.

### Parliament

We organised a meeting, in the House of Commons with Jeremy Corbyn's help on 30th November which was well attended by our members but sparsely by MPs. Caroline Lucas spoke and Diane Abbott came and contributed. Peter Fisher and I went to see Diane Abbott, and on 12.9.11 Harry Keen joined us in a meeting with John Healey, which were both pleasant but unproductive.

On 17.1.11 we held another meeting on the day the Bill was published, having written to all MPs. The response was poor, although Ilora Finlay came

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from House of Lords. Dr Richard Taylor spoke and suggested that we tried mounting candidates for parliament or local elections, but we did not think this was feasible. Frank Dobson hosted this meeting.

We have also emailed all MPs from the other three nations to whom the Bill does not apply, with two replies from Northern Ireland. In March we e-mailed all MPs saying the Bill should be withdrawn, with a couple of replies from LibDem MPs.

In November I went to see Shirley Williams and following her advice arranged for two letters to go to the Times signed by over 200 doctors in December and almost 400 in January - thanks to NHSCA members who signed. We took copies of this list with the letter to the DH for Andrew Lansley which generated some publicity in GP magazine.

We made a list of the most marginal constituencies, sent this to groups and provided model letters on the website for people to use which were updated after the 'listening exercise' and Future Forum report. Feedback has been poor with only a handful of people sending letters to us from their MPs.

I have been in close touch with Evan Harris who asked me to speak to the SE Region Lib Dem conference in early March and at a fringe meeting at their spring conference on 14.3.11 with Shirley Williams, Paul Burstow, Charles West, a doctor, and Evan himself on the platform. I have kept in touch with Evan & Shirley Williams whom I saw in October and again with Morris Bernardt on 1.11.11. I went to see Tim Farron, who is the President of the LibDems, with a constituent in late March, and again in June he said Nick Clegg was working behind the scenes on Cameron. He had considerable doubts about the amended bill but abstained at 3rd reading when only 4 LibDems voted against. One of these was Andrew George with whom I have also been working.

Harry Keen and Robert Elkeles and I went to see Robert Winston in the Lords, and I attended the Unite evening reception for MPs and Jacky Davis went to the tea party for the Lords. Before 3rd reading we sent a dossier produced by Jacky Davis and Adeline O'Keefe to all LibDem MPs from KONP & sent an updated version to the Lords on 22.9.11 from NHSCA. We are continuing to campaign in the Lords. We Press released this on 27.9.11. I am working with Lord Owen, Lord Rea and Baroness Tonge. Mailing the dossier to all members of Lords (via the internal post) has made a dent in our finances.

### **Working with the BMA**

We had a successful joint meeting with the BMA London Regional Council after the critical report on NHS London's proposals. We hoped to have a second meeting, but this did not happen. Only three members of the BMA Council voted to have a Special Representative Meeting (SRM) proposed by Jacky Davis. I then tried to mobilize Hon Secs to call for one. The support of thirty divisions was needed but only five asked for a meeting. Within the BMA Council Jacky Davis and four others fought for this and on 15.3.11 it happened. Despite the motion asking for the Bill to be scrapped being passed in the morning, by the end of the day a motion saying the BMA rejected the Bill in its entirety was narrowly lost as was a vote of no confidence in Andrew Lansley. At the ARM in June 2011 we had to fight to get the H&SC Bill debated and again a motion saying the Bill should be withdrawn was passed by a substantial majority but outright opposition was lost 51%-46% after Hamish Meldrum said it would tie his negotiating hand. Council then passed a motion in July endorsing the withdrawal of the Bill and calling on the BMA to mount a public campaign. This has been notable by its absence. On 24.9.11 we sent the Dossier to all College Presidents urging them to call for a Select Committee minimal response

### **Demonstrations and rallies**

Adeline O'Keefe spoke at the Coalition of Resistance march and Rally on 22.10.11, Jacky Davis at their meeting in November 2010 which was posted on You tube and I spoke to them on 9.7.11. Local groups have held marches and rallies throughout the year and several KONP groups joined the TUC demo on 26.3.11

Bronwen Handyside and Hackney KONP organised a demonstration outside the London regional BMA evening meeting on 4.11.10, Adeline and Bronwen did the same during the day on 15.3.11. Candy Udwin of Camden KONP liased with Unite and organised a march and demonstration on 17.5.11 from UCH to Richmond House and Nick Bailey of Hackney KONP and Adeline organised a protest outside the Commissioning conference at Olympia in June. KONP members also joined protests organised by students in London. I spoke at the Unite rally outside Parliament on 5.7.11 NHS birthday. Candy Udwin organised a march from St Thomas' Hospital to Parliament on 7.9.11 to join the TUC candlelit vigil. Lewisham KONP picketed BBC Question Time when Lansley was speaking and Helmut Heib was selected to ask a question.

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## Speaking Engagements

John Lister, Jacky Davies, Colin Leys, Jonathan Tomlinson and I have addressed meetings in several places in London, Oxford, Leeds, Southampton, Norwich, Liverpool, Portsmouth, Nottingham, Bath and Stroud. Others have also spoken on behalf of KONP and Peter Fisher has circulated the NHSCA members and we have another 12 volunteer speakers to add to our original list, which had dwindled due to death and ill health. This will be circulated to groups when finalized. Jacky Davis took part in the Guardian roundtable discussion on health and in the Guardian blog along with Jonathan Tomlinson.

The AGM on 25.6.11 was a great success with almost 100 attending. Allyson Pollock who brought a colleague from US Wendell Potter, Clive Peedell and Ron Singer spoke and thanks to the number of doctors attending and a generous donation we made a profit of almost £900.

## Groups

The good news is that we have had five new groups launched formally, Lewisham, Lambeth, Lancaster and Morecambe, Leeds and Norfolk. I learnt via Manchester that a group has been meeting in Congleton. We now have 19 active KONP groups in England and one in Wales.

Three groups have disbanded, Maghull, Robin Hood and Warwickshire, and some seem pretty inactive. Oxford, Cambridge and Newcastle and North East have revived, as has Nottingham and Nottinghamshire in expanded versions. Sheffield may revive, but Bristol, Crawley, Southampton, Newham, and Northampton are quiescent- or moribund as one activist from a cuts organisation said.

## Finance

We were grateful to get another small grant from the Andrew Wainwright trust and with the grant given by the NHSCA are solvent and have enough in reserve to keep the organisation going for another four months. NHSCA have given us a quarterly grant of £1500 for which we are very grateful. We need at least £1000 a month for administrative costs and thanks to NHSCA members, SG members and my friends we have managed to get £960 in standing orders. Thanks to all those individuals who are contributing regularly. If you could afford to do a S/O I promise I will cancel it when KONP ends.

Letters to the Guardian from Jacky Davis, Peter Fisher, Jonathan Tomlinson, Peter Draper, David Wrigley and I have been published and do generate interest via the website but rarely cash, Louise Irvine from Lewisham KONP organised one in the Telegraph from GPs in June. Do write to your local papers - it helps to spread the message.

Our Facebook group has grown but not dramatically. We have made links with other groups such as 38 degrees, and Big Society NHS. Jonathan Tomlinson has a great blog called ABetterNHS and Richard Blogger is also useful.

**WENDY SAVAGE**  
**Co Chair, KONP**

*A sample car sticker is enclosed – please display.  
Further supplies can be obtained from -  
KONP, c/o 19 Vincent Terrace, London N1 8HN  
Cost – 75p each £6.50 for 10 (inc P & P)*

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# NHS Support Federation

campaigning to protect and promote the founding principles of the NHS

## Campaigning to stop the health bill

The Federation has been running a campaign against the government shake-up of the NHS since their ideas were first launched in a White Paper last summer. There was a clear need to alert the public and actively oppose these plans. Early on we signed-up 12 major national trade unions and groups like the National Pensioners Convention to the campaign, to help raise awareness. They distributed our briefing material throughout their networks. 35,000 people signed up to our national petition (including prominent public figures like Polly Toynbee and Michael Mansfield QC). It received national press coverage and was used to collect support across the country. Our website

was visited by 20,000 people a month throughout the year, for campaign information and resources.

At first MPs were slow to respond to the plans, so we launched a lobbying exercise to persuade them that the public were genuinely concerned. Our arguments were compiled in simple, evidence based briefings. We were asked by the Labour Party to provide additional material for their MPs and our fact sheets were quoted in several Parliamentary debates. Our campaign materials were also adopted by UNITE and distributed across the country. We worked with UNISON, BMA and the other health based unions in organising constituency based lobbying days.

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Once the build up in public pressure had led to a pause in the legislation, the Fed lobbied the Future Forum and encouraged the public to do the same. We organised two public opinion polls which helped to advertise the level of public disquiet through national media reports. The latest showing that half the public want the bill to be dropped altogether, even after its revamp.

As the bill enters the Lords the Fed is working with UNISON and UNITE in lobbying to achieve further changes and this is also an opportunity to influence the health policy of the opposition parties. We are organising a public meeting in the House of Commons on 11th October – where Shadow Health Secretary John Healey and journalist Polly Toynbee, will be speaking.

### **Research: the impact of reform**

The Fed is compiling a report on the growing number of corporate providers that are preparing to bid to run NHS hospitals and other clinical services. The document looks at their business history, financial investors and strategies and has uncovered companies connected to fraud, kidney trading and diamond mining. The report also explores the likelihood of further Southern Cross-style collapses.

Over the last 2 years we have built up a national data base of NHS clinical contracts outsourced to the private sector, as no such record is currently being centrally kept. We will use this baseline to track the impact of the current reforms and to help quantify the extent of privatisation. We are also starting to collect data on the performance of the new clinical commissioning groups.

### **Launching the Fed as a campaigning charity**

After 22 years of campaigning the Federation Executive decided during a strategic review, that there remains an ongoing need for a national organisation that brings together the public and NHS staff to protect and promote, the core principles of the NHS. However we need greater resources to be effective and sustainable. We therefore hope that this new charity will help to achieve this and look forward to expanding our work in the future.

We would like to thank the NHSCA and its members for all their generous and active support over the last year. It really does make a difference to what we can achieve and has been crucial in raising the pressure on the government and letting the public know what is really happening to their NHS. For more information about our work visit our website [www.nhscampaign.org](http://www.nhscampaign.org) or contact [paul@nhscampaign.org](mailto:paul@nhscampaign.org)

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## Conference - Part 1

### ‘Burying the Bill’ How can we best influence the various groups?

Our co-chair of NHSCA and BMA council member Jacky Davis gave the first talk on:

#### **The Medical Profession.**

She wondered, how, as 90% of the 180,000 doctors in England were against the bill, it was still proceeding. Why are so many apathetic? The majority of GPs are against it as they realise that their relationships with patients will be fundamentally changed and they will be blamed for rationing of treatments and for closures of units.

Why are hospital doctors not more outspoken in their opposition? Private firms will cherry pick easy cases normally dealt with by NHS hospitals thus reducing their income leading to likely closure of units and also reducing the training opportunities for junior doctors. In her experience most remained unaware of the profound implications of the bill and the way in which medical practice would change as a result. If they did realise the consequences many were afraid to speak out and most thought the changes were inevitable and little could be done to alter the course of events. The government only really seemed to listen to the small group of entrepreneurial GPs represented by National Association for Primary Care and the NHS Alliance.

She felt strongly that we had been badly let down by our leaders eg the Presidents of the Royal Colleges who had not sought the views of members and were

not representing the views of their members. Likewise the message from the BMA had been weak. They had all been fooled by talk of significant amendments arising from the so called listening process. These were illusory.

She suggested a number of ways in which the message could be conveyed more widely

1. By writing articles and speaking at public meetings and the use of social media.
2. Encourage people to join groups opposing the bill.
3. Greater visibility of opposition.
4. Engage medical students. She had found that they became vociferous when informed of the changes.
5. Work inside existing organisations such the BMA and its branches and unions such Unison.
6. Approach the Royal Colleges to adopt a more robust stance.
7. Help to fund organisations such as KONP which actively campaigning the bill
8. Refute the idea that the passage of the bill is inevitable. The argument that it is too late is wrong.

In the ensuing discussion some felt that some consultants were in favour of the changes because they felt that, mistakenly, their private practices would benefit. There was also a feeling that the Royal Colleges should have consulted their members and taken more robust action in the light of their views.

**ROBERT ELKELES**

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# Ruth Marsden, Vice Chair, National Association of LINks Members

With a vast experience of politics and knowledge of politicians, and how to relate to them, Ruth wasted no time in advising the meeting what its priorities should be—"Not only is the Health Bill huge, complicated and impenetrable and set in a very large Lord's agenda, but there are only 10 days in which to focus the Lords on the important issues. They are not used to being talked to deferentially. Best to use simple dramatic language and metaphor which they will remember. They need proper evidence and only a few amendments to consider. A nominated person needs to package the bullet points agreed by the meeting."

Speaking privately afterwards, when asked how she thought we might influence the public in burying the Bill, she replied "At this late stage, involving the public is a sideshow. The public don't even understand the rudiments, such as the structure and function of a PCT."

**GEOFFREY MITCHELL**

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## The Nursing Profession

### **Gill Poole: Nurse Manager and Health Visitor**

Gill has spoken to a wide variety of people about the Health Bill, including the RCN, the Chief Nurse and 38 Degrees campaigners.

Nurses have very great concerns. One of these is nursing numbers, as 65% of the 400,000+ qualified nurses are now over 40 years old while only 9.3% are under 29. Student nurse numbers are to be cut by 10% next year.

The Bill, in combination with the cuts, is likely to have a great effect on patient care. The fragmentation resulting from the policy of 'Any Qualified Provider' will result in loss of coordination between different services, while competition between providers will mean a 'drive to the bottom' for quality. Even now, many frontline posts are frozen and 27,000 posts have been axed. Competition is likely to reduce nursing numbers even further. Much skill and experience will be lost, while the financial cuts are already affecting nursing education and CPD.

In recent years a massive amount of time and resources have been put into Agenda for Change. Local pay bargaining will mean all of this has been wasted, as well as threatening terms and conditions and pensions.

What do nurses think of the Bill? Gill does not work for a Trust so is able to speak freely but most nurses are frightened to do so. The RCN voted overwhelmingly for 'no confidence in Mr Lansley' and was disappointed that he only spoke to a small group and not to the whole conference.

How can nurses be engaged in fighting the Bill?

Could nurses be invited to meetings, and allied professions as well? Most of the issues relating to the Bill are common to all healthcare groups. Facebook and Twitter may provide opportunities for engagement but time is now very short.

Gill feels that Peter Carter does not represent the views of grassroots nurses, though most nurses are members of RCN. There is a lot of discussion on websites and most nurses are unhappy with the Bill.

Clive Peedell pointed out that the Bill could not be enacted if all medical and nursing groups came out together against it, and that the National Association of Primary Care is writing commissioning policy even though it represents under 20% of GPs. Patrick Zentler Munro felt we should challenge GP commissioners more about why they are pushing the Bill through even though most GPs, even those in commissioning groups, are opposed to it.

Wendy Savage wondered how nurses can be mobilised, in view of the RCN's 'spineless' stance. The RCN criticised Hamish Meldrum for 'being too critical of the Bill!' Gill had no clear answers to this.

Clive Peedell stressed how crucial it is to get the message out now. It will be very hard to reverse these changes if the Bill goes through and there will be no appetite for further upheavals. He also mentioned that Oliver Letwin, in his 1988 book, described 'privatisation' in terms of exactly the changes planned in the Bill, and also advocated a policy of 'divide and rule' between doctors and nurses.

**ANDREA FRANKS**

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# “Burying the Bill”

## – what did Evan Harris have to say?

Evan Harris began by assuring us (if that is the appropriate way of describing this!) that the Bill would pass into law eventually, come what may. While he supported the proposal by Lord Owen to set up a special Select Committee to investigate the Bill in detail, he stated that he rather doubted that the House of Lords would accept this (subsequently his doubts proved to be well justified!), as their Lordships (especially the cross benchers, so he claimed) do not like to seem to be blocking government bills in principle. So while it might be sensible to support Lord Owen over his proposal, he stressed that, in the longer term, amendments designed to improve the bill radically, and to make it less damaging to the NHS, would appear to provide a strategy more likely in the end to be successful.

Dr Harris then proceeded to recommend amendments which he suggested should be given highest priority by those seeking seriously to reduce the potential damage to the NHS; these included:

- Removal from the Bill of all references to “competition”, whether in reference to “Monitor” or to any other body; instead the Bill should require “Monitor” to promote integration of health services;
- As well as enabling choice between alternative health service providers, the NHS should be required to promote both equality of access to services and equality of health outcomes;
- Greater safeguards against hasty or rash decisions to sell off NHS assets should be ensured;
- To prevent NHS bodies from competing in the private health care market, the cap on private patient income that Trusts may receive should be retained;
- The direct responsibility of the Secretary of State to secure provision of NHS services for the public should be restored;
- The current arrangements for local authority scrutiny and overview of NHS performance should be retained;
- Boards of Trusts and other NHS provider organisations should include a majority of directly elected members;
- Outsourcing of responsibility to commission health services to private organisations should be outlawed specifically;
- It should be a legal requirement that commissioning decisions should be needs-based, and that the geographical areas for which commissioning boards are responsible should be coterminous with those for matching social services organisations;
- There should be restrictions on the right to purchase private care in the context of personalised budgets;
- Within the restructured public health departments, the rights of directors of public health (and of other consultants) to full professional independence must be guaranteed, and they must be free to speak out “without fear or favour” on health threats to their local communities, and to participate in health advocacy seeking to influence public policy at all levels;
- Commissioning and contracting between NHS bodies must ensure that other services (such as undergraduate and postgraduate education, or nursing education) are not damaged by such contracts.

Evan Harris was speaking to an audience in York which was in a collective depression regarding the bleak future apparently in store for the NHS, and, while trying to ensure that what he was recommending was realistic, his list of possible improvements to the Bill, which appeared to be potentially within reach in the House of Lords, helped at least a bit to raise slightly the collective mood of his audience.

**CHRIS BIRT**

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# Conference - Part 2

## Healing the Split

### Scotland vs England:

#### A Paper by Matthew Dunnigan

The increasing contrast between the Scottish (Welsh and Northern Irish) Health Services (a decreasingly privatized and increasingly collaborative service) and the English Health Service (an increasingly privatized and competitive service) has long been the subject of interest but not, unfortunately, intelligent comparison informed by comparable and worthwhile outcome measures.

The publication of the Nuffield Trust Report in 2010 was therefore welcome, but its results counterintuitive at least to members of the NHSCA and other supporters of a publicly-funded and publicly-provided NHS: it reported that Scotland, in particular, was performing less well – in what it chose to define as “productivity” – than England. Was this the result of ill-informed or biased analysis, or was it correct: had NHSCA lost one of the few potential pieces of hard evidence supporting its views?

Matthew Dunnigan addressed this question by adding to the incomplete data in the Nuffield Report, allowing him to plot annual trends in hospitalisation rates per 1000 population over a period of 11 years: from 1998-99 to 2009-10, straddling the divergence of the two health systems with the abolition of the internal market in Scotland in 2003-4. He used several measures which, although not clinical, could be termed measures of “outcome” rather than “productivity”, and which were directly comparable and relatively unambiguous in collection. He noted from his data (see NHSCA Newsletter for June 2011 and on the website), in papers tabled before, and presented to, the AGM that:

- Admission rates rose by only 0.07% p.a in Scotland vs 2.4% in England
- A&E attendances rose by only 1.1% p.a. vs 4.2%
- New outpatient referral rates rose by only 0.4% p.a. vs 6.1%

and in each case hospitalisation rates were higher in Scotland than in England at the beginning of the decade in question, and lower at the end. Corresponding with this, Scotland performed better in terms of waiting lists for specific elective inpatient procedures in each year from 2005-6 to 2009-10 – although admittedly England came a close second, Wales and Northern Ireland lagging far behind.

What does this mean? Either that the Scottish population is neither seeking (A&E) nor obtaining (out-patients, admissions) the health care it needs, (very doubtful) or that the internal market operating in both countries at the beginning of the decade was operating perversely to increase demand above need. More probably, in Scotland, abolition of the purchaser-provider split allowed supply and demand to equilibrate, whilst in England financially incentivized (PBR) activity – one hesitates to call it “productivity” – continued unchecked, unrelated to need or perhaps even demand.

Dr Dunnigan also noted from his data:

- That all-cause, cardiac, respiratory and cancer mortality fell equally in both countries over a similar period
- That demand for elective care (new OP referrals) increased in Scotland by 6% of the rate in England, whereas demand for emergency care (A&E attendances) increased by 25% of the rate in England – indicating, Dr Dunnigan argued, that what could be planned for (but, perforce, purchased in England) was better provided for in Scotland.
- That Scotland achieved a 95% reduction in delayed discharges, almost 100% compliance with the four hour A&E waiting time target, and the highest public satisfaction score offer for countries in the UK.

What about “productivity”? Per capita expenditure increased by 9% per annum in Scotland and 10% in England, in real terms, over the decade in question. This would indicate a decline in “productivity” in both countries which, given the lesser increase in activity in Scotland, would be greater in Scotland. So much for “productivity”, if it is simply measures patient turnover unrelated to need, outcome or satisfaction. Productivity would, in any case, have been predicted to decline over the decade in question with the introduction of the new consultant and GP contracts with, significantly – and unpredicted by the government – a major reduction in working hours. The fall in specific mortality rates, however, perhaps suggests a remarkable improvement in productivity!

**PATRICK ZENTLER-MUNRO**

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# John Connaghan, Director Of Workforce & Performance Scottish Government Health Department

## The NHS in Scotland

John Connaghan has over 20 years experience in management in the NHS in Scotland. Initially he was the chief executive officer in a teaching district general hospital in South Glasgow, being appointed when the internal market was introduced in 1989. He is now a senior civil servant in the Scottish Government Health Department.

He outlined that from the inception of the NHS in 1948 until 1989 when the internal market was introduced throughout the UK there was a philosophy of central "command and control". With the advent of the Scottish Parliament in 1999 when health matters were devolved, there was a progressive move away from competition and the internal market. A White Paper published in 2003 entitled "A Partnership for Care" paved the way for a Bill abolishing the market. Since then the emphasis in Scotland has been towards an integrated system of health care. There are 14 main health boards which cooperate, rather than compete with each other. The management is stable and there are well-defined organisational boundaries (mostly contiguous with local authority boundaries), which make integrated healthcare easier to achieve.

The Cabinet Secretary for Health holds annual reviews with the Health Boards, and these are held in public, with in recent years the Cabinet secretary. Recently the Cabinet Secretary has answered unvetted questions from the floor for a significant period of the meeting. The Health Boards are set ministerial targets in relation to health improvement, efficiency, access to services, and availability of treatment (HEAT targets).

Originally the Barnett formula gave Scotland 20% of extra funding per capita, but this has been progressively reduced, to its current figure of 5%. HM Treasury sources indicate that Scotland currently spends £2089 per head, versus the London figure of £2249. The use of the private sector (to meet target waiting times) is currently 7%, at £8.05 million - a fall from £23.8 million in 2008.

The proposed reduction in the Westminster block grant to Scotland as a result of the recent financial crisis, will mean that maximum fall of £38 billion will be reached in 2015/16, and this will not recover in real terms to the current expenditure until 2025/26.

Within Scotland, there is a significant variation of health spend per head. In Greater Glasgow and Clyde Health Board (the largest in Scotland) the cost is £1941 versus £2787 in the Western Isles Health Board. However caution should be observed when making comparisons, and factors such as deprivation, geography, definitional differences etc have to be taken into account.

United Kingdom comparative waiting times for 11 inpatient procedures shows that from 2005/6, Scotland has the lowest median waiting time for seven of the 11 procedures, which range from cataract surgery to total hip replacement.

Between 1995 and 2010 in Scotland, the three big killers of coronary heart disease, stroke and cancer have shown respective decreases of 60%, 54% and 22%.

The hospital acquired infection of *Clostridium difficile* has fallen by 71% over a period from March 2006 to May 2011.

Quality strategy surveys have shown that 85% patients rate the service as good or excellent.

There is a first-class partnership working in the Scottish NHS, and this stands out as a distinct and novel approach which has survived for more than a decade, and withstood changes in administration and NHS reorganisation. This has been the subject of a study by academics in Nottingham University.

Immediate priorities are the integration of health and social care, the introduction of selective unit pricing for cheap alcohol products, detection of early cancer, enhancing the quality strategy, and developing the workforce.

**ROBERT LC CUMMING**

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## A Welsh Perspective

The session was brought to a spirited close, by **Mark Drakesford**, Member of the Welsh Assembly and Chair of its Health and Social Care Committee. In buoyant terms he described the current status of the devolved Welsh NHS – no Foundation Trusts, no PFI, no private sector clinical sector, no prescription charge, no purchaser/provider split, no market. The NHS internal market operating with 22 Local Health Boards and 7 Trusts was bureaucratically top heavy

and the market was abandoned in early 2009, being replaced with 7 Regional Boards and 3 Trusts with representative composition and integrating health and social welfare, primary and secondary care, public health and local authority. NHS Wales still has its challenges, Mark Drakesford told us, but it faces them collaboratively rather than competitively and he paid tribute to the vision and determination of the recent Health Minister, Edwina Hart.

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The NHS in Wales is best described by the “three Ps”, he felt. First, Politics. Wales has a collectively minded social culture based on its industrial past. It was true to fundamental Labour Party values and inimical to a health-care market. Second were Policy Principles, growing largely out of devolution, favouring the principle of universality of services, on collaboration rather than competition, on citizens rather than consumers/customers and on democratic decision making - “voice, not choice”. Finally Professionalism rather than commercialism. This he felt was central to maintaining a relationship of trust on which personal services depended for most efficient and effective running.

Finally he stressed the importance of seeking “equality of outcome” rather than equality of input in respect of health and social services. “To each according to his/her needs” rather than a system which dealt out an equal ‘ration’ to everyone was an important policy issue they were tackling. Unfortunately time was late and there was little opportunity to explore the detail of operation of NHS Wales but it was clear that many of the market-engendered restrictions and frustrations had been relieved and we look forward to sound comparative data which support the clear impression that NHS Wales is working well “beyond the market”.

HARRY KEEN

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## The Paul Noone Memorial Lecture

### Health Systems change: from dynamics without change to real reform - David J Hunter

Professor Hunter is director of the Durham University Centre for Public Policy and Health (CPPH), and professor of health policy and management. The main areas of interest of the CPPH are public health policy and management; evidence, decision-making and policy implementation; inequalities in health; and health effects of public policy. He mainly undertakes research on aspects of public health policy and practice, including partnership working and health system transformation. He also helps run leadership programmes in health improvement and wellbeing.

#### **‘Dynamics without Change’**

Professor Hunter invited us to stand back and consider a wider picture than just the current Health and Social Care Bill. People like us are often accused of looking back and not wanting change, so what are we offering as an alternative to the present structural change towards marketisation, which has little evidence base? He said that for 40 years, reform has been little more than multiple ‘big-bang’ structural changes, in spite of evidence that they have limited value. They consume significant human and financial resources, but produce little improved health outcomes or better performing organisations. They could therefore be said to be both immoral and unethical.

David Hunter asked what might be a different path to change? His central thesis is that the way to get effective reform, i.e. that which will really have beneficial effects, is not by structural change per se, but by cultural change in the way organisations work, (but still firmly within a public sector framework). For example, Don Berwick said, on the restructuring problem in the NHS: “.....the leaders of the NHS and government have sorted and resorted local,

*regional, and national structures into a continual parade of new aggregates and agencies. Each change made sense, but the parade doesn’t make sense. It drains energy and confidence from the workforce, which learns not to take risks but to hold its breath and wait for the next change. There comes a time, and the time has come, for stability, on the basis of which, paradoxically, productive change becomes easier and faster for the good, smart, committed people of the NHS.”* So a prerequisite for real reform is organisational stability, which is needed to obtain productive and sustainable change.

David Hunter also suggested some symptoms of failure in health systems, drawing on the current evidence base:

- Persistent financial, quality and/or safety problems.
- Management distracted by constant ‘re-organisation’—short-term policy and priority changes, rather than thinking long-term.
- Low staff morale, including clinician disengagement.
- Weak implementation of policies and plans.
- Policy incoherence—policies which push and pull in different directions, for example the perverse incentives resulting from the introduction of ‘Payment by Results’ which rewards hospital activity at a time when government policy is to keep patients out of hospital as far as possible.
- Poor leadership in handling complexity and problematic issues.
- Lack of political will.
- Absence of cooperation across a care pathway, or not having a total system approach, which can introduce perverse incentives against co-operation, as noted in a recent King’s Fund report on integrated care.
- Inter-organisational relationships are often undeveloped.

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David Hunter also noted the 'dynamics without change' phenomenon: *"Any suggestion of real reform has been a deceit. Working patterns, practice and custom are at the heart of many capacity issues [in the NHS] and have never been challenged. It is extraordinary the gap between highly motivated frontline staff and the systemic dysfunctionality in which they operate."*

### Real Reform

David Hunter stated some essential elements of real reform:

- Escape from 'mind traps,' that is a (too) familiar path dependent approach, always retreading the same path, i.e. 'path dependency'.
- Focus on service redesign.
- Remove waste and variation.
- Improve quality.
- Use evidence to guide decisions.
- Work collaboratively across boundaries.
- Nurturing high trust relationships with local partners.
- Importance of appropriate leadership.

In addition, research conducted jointly by McKinsey's and the London School of Economics in 2008, has highlighted the characteristics of high-performing hospitals, none of which have anything to do with structure. They are:

- Lean management—a hospital's operational effectiveness.
- Performance management—the creation and use of clinical quality and productivity targets in managing operations, including by clinicians.
- Talent management—the recruitment, development, rewarding, retention of high-performing staff: e.g., rewarding high performing staff match post and skills.
- Clinical leadership—the way the roles, skills, mind-sets of hospitals doctors contribute to the management of clinical services, e.g., clinicians being at the centre of the way health services work.

Other studies bear out and support some of these points. For example, the Boorman (2009) Review of NHS Health and Wellbeing, commissioned by the last government, noted that good performance depends on good staff relations, which result in:

- Improved quality and organisational performance.
- Patient satisfaction.
- Increased productivity.
- Simple good management practices.

David Hunter further illustrated how improvements could be achieved within existing arrangements, by pointing to some key features from the North East Transformation System (NETS) initiative. The

NETS' three elements have a triangular relation: Vision, Compact and Method.

The Vision comprises seven 'Nos':

- No barriers to health and well being.
- No avoidable deaths, injury or illness.
- No avoidable pain or suffering.
- No helplessness.
- No unnecessary waiting or delays.
- No Waste.
- No inequality.

The Compact refers to working as part of a team to avoid the 'Nos', using a psychological contract to structure and govern the relationships between clinicians and managers.

The Method, ensuring change in the delivery of care, is based on lean thinking and tools as used in industry and increasingly in parts of the NHS.

The key defining feature of the NETS is the strong commitment from NHS leaders at all levels to making this new way of working succeed. The core idea is to get everyone to work together in a context where high level trust and respect are in place. For example, using this approach, a reconfiguration of mental health services in a mental health trust produced better working practices, including more efficient care for patients, with the result that fewer inpatient beds were needed.

NETS was implemented in a relatively unhealthy population in NE England. Despite good health services there, which met all government targets, it was felt that the system wasn't performing well enough and doing too little to improve health. NETS and initiatives like it, aim to change the culture and the way work is done, to make it more efficient and effective. But they are at risk from the proposed structural and market-style changes, which threaten leadership commitment, sustainable change and collaborative working.

### Future of Leadership and Management

David Hunter pointed out that the main NHS hierarchies, despite their rhetoric, want 'followers' to do what has always been done in terms of carrying out the government's bidding, rather than 'leaders'. But, he said, leadership is about changing what has been the norm and challenging the prevailing orthodoxy where it is known to be flawed or defective, or runs counter to the values and principles underpinning the NHS. Integrative leadership is crucial because in complex undertakings like health care, collaboration, team work, working with people, rather than heroic leaders pushing their own agendas, are the features that, above all, are needed to ensure continued public support.

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Leadership needs to be shared and distributed in a complex activity—there is much evidence to show how it should be done, but it is difficult to pursue effectively because of all the structural changes going on. These pose a distraction and do not allow for the creation of the optimum conditions for making the sorts of the changes which he discussed.

### Cautions

Professor Hunter concluded with some cautions:

- Past experience tells us that omens for real reform, rather than mere structural change, are not good.
- The power of the 'legacy model' remains strong—each person in power wants to leave a tangible legacy which usually entails a structural change of some sort since this is both visible and quickly achieved. For these reasons, structural, and not cultural, change still holds sway.

In short, the present Health and Social Care Bill is a million miles away from offering a way forward which will truly transform health care in England. It is a missed opportunity and simply repeats what has been tried many times before with little success.

<sup>1</sup> National Audit Office Reorganising central government. London: the Stationery Office, 2010.

<sup>2</sup> Berwick D. A transatlantic view of the NHS at 60. *BMJ* 2008;337:a838

<sup>3</sup> Aidan Halligan, former Deputy CMO, quoted in the Daily Telegraph 2006 <http://www.telegraph.co.uk/news/uknews/1519631/Open-wide...-Why-big-business-is-being-invited-to-run-GP-surgeries.html>

<sup>4</sup> <http://www.nhshealthandwellbeing.org/InterimReport.html>

<sup>5</sup> <http://www.northeast.nhs.uk/vision/nets/>

### Discussion

**Comment/Question (C/Q):** given the situation of the Bill, what should we do?

**Answer (A) David Hunter (DH):** changes in the NHS are already being made even without the Bill. So we need to move to a different arena. The problems (and the devil) are in the detail and we will need to see what will happen locally as a result of the present changes. Therefore try to re-direct change locally in your practice. The Bill might become increasingly irrelevant if what is already happening locally continues.

**C/Q:** Peter Draper: policy development is weak at present. This top-down government is very good at PR but poor with policy. Where are the think tanks? For example, is the King's Fund too close to the service?

**A. DH:** yes, they are all too much of the same mind-set and over the years have become too close to government to remain independent. They would argue that being 'critical friends' entails being close, but it's a fine line between being close and remaining independent.

**C/Q:** Wendy Savage: will the Bill set marketisation in stone?

**A. DH:** Things will happen anyway, as they are already doing, but will become much worse if the Bill is passed. The 38 Degree legal opinion suggested New Labour had already unleashed a lot of changes which opened the NHS up to EU competition law.

**Wendy:** the way is to get rid of purchaser/provider split.

**DH:** I agree, but if you want integrated care you need integrated providers. The King's Fund has suggested abandoning the purchaser-provider split and encouraging competition among these new integrated care organisations.

**C/Q:** What message should we be giving to clinicians?

**A. DH:** many clinicians do not know enough or understand how the NHS works which is a great pity. They are often ignorant of its history and how it compares with other systems. There is a need to raise awareness of leadership and management among clinicians and to reflect this in medical training and the curriculum. Strengthening clinical leadership, as Darzi and others have argued, is essential for the future of the NHS.

**C/Q:** Clive Peedell: clinical leadership is crucial. Market reform undermines professionalism. But some people think that a public service ethos no longer exists, so that market discipline is needed.

**A. DH:** if the Bill goes through we need to fight its impact on the NHS and defend the public interest ethos which underpins it.

**C/Q:** Peter Fisher: we need to keep arguing against the case that present problems are caused by delaying the Bill. This idea should be laid to rest. We should argue that any problems caused by delaying the Bill are entirely the responsibility of those who chose to start implementation in advance of full parliamentary approval.

**C/Q:** Allyson Pollock: present changes might well be open to legal challenge. Clinical Commissioning Groups (CCGs) should statutorily have no power: there are supposed to be big NHS cuts, but CCGs are being paid extra to what was the commissioning budget. However, it costs a lot to make a legal challenge.

Clive Peedell thanked David Hunter for his informed and stimulating lecture and discussion.

DAVID LAWRENCE

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# Psychiatry - In The New Front Line

Although the phrase 'Cinderella service' is rather out of date now, not least when you see some of the really rather pleasant modern psychiatric units, Psychiatry continues to suffer from a significant difference in the way it is understood by the powers that be, for example Strategic Health authorities. Thus they have yet to really clarify how much psychiatry costs, and have avoided the PCT Commissioning exercises that have helped clear up how much hospitals and their operations might, at least theoretically cost. They have shied away until recently from imposing the kind of quantifications associated with 'payment by results' (PBR), but since no-one knows how much it costs it becomes easier to cut it. This may seem paradoxical, but it is quite easy to deny core facts and figures that didn't exist in the first place. Cinderella has joined Alice in Wonderland.

While it is reasonably straightforward to put a cost on a standard cold surgery case, for example a hernia repair, and we know the extent to which the typical ISTC has cherry-picked healthy patients away from the hospital for routine operations, it is much more difficult to cost an episode of, say, home care by a community psychiatric nurse (CPN). There is no particular outcome or even QALY in terms of the patient getting better, or even going back to work, although from the patient's point of view there is a rather important outcome, they don't feel lonely, they have their benefits sorted out, and they continue living in their home. But since the PCT would not have made any explicit statement about the cost of providing this care, apart from insisting on certain generic teams, cuts can be made without any obvious reduction in reported turnover (there are no less operations or less visits apparently), and the patients themselves are most unlikely to complain. Not only does the stigma of psychiatric illness affect individual patients and their families, but it generates a cynical willingness in purchasers to assume that they can make reductions in scarce services without too much noise being made. Dying babies and men in their prime having heart attacks look very bad in the newspapers. A patient with chronic schizophrenia being visited once a month instead of once a week can easily be camouflaged amidst phrases like 'more focused care', or 'personal choice' with regard to self recovery and independence.

The most obvious funding impact on psychiatry has been the gradual de-nuding of a range of generic teams (set up about 10 years ago and onwards) to enhance the quality of outreach care. Instead of a single community mental health teams (CMHTs), uniting care across wards and the local community, teams known as Assertive Outreach, Home Treatment, Crisis Intervention and Early Onset were created to cover the gaps in standard community provision. In part they had to be constructed as such

in order to get the funding through un-scathed from Strategic Health Authorities to the front-line (much mental health funding disappears on route), and in that they were successful. Additional staff, active interventions, and good patient feedback resulted, but of course part of the deal was cutting our acute beds. Now these teams are being gradually shredded (for example losing 30% or more of their staff), to varying degrees, and in ways that are very difficult to find out about or unravel. And they certainly have NOT restored the beds!

The result is a gradual withdrawal of these teams from the kind of regular input they have provided, reduced care and treatment, and the continuing climb in the demand for hospital in-patient admission but of course the beds are not there. The traditional service providers (CMHT and acute wards) thus have an increasing burden of seriously psychotic individuals, requiring quite intensive care and as often as not its the Mental Health Act that's needed to get that care.

Alongside this gradual lack of outreach support through deprivation of staff numbers (and people and their time are of the essence), most social services departments have had to undergo cuts as well. What does this mean? In the city where I work it has meant that the funding for supported housing is not available, patients are pushed into more 'independent' situations, where they often cannot cope, and relapse sadly occurs. They get back into hospital and the merry-go-round continues. Thus the gains of a most positive input into properly funding care in the community are gradually being eroded, via a combination of centralist risk management forcing people into more restrictive approaches, and stripping out of the regular supportive teams. Strict limits are put on new medications, which may not be too inappropriate given the limited benefit they often bring, and many patients are pushed back to primary care, the poor old GP already handling a number of other chronic diseases like diabetes.

The problem is that these insidious cuts, across the psychiatric and social perspective, will not have an overt and immediate impact. They will however lead to a deterioration in the quality of care people receive in hospital and out of hospital, increasing isolation of troubled souls in the community, and a gradual reversion to the kind of scenario so apparent in any American city. That is the stage-army of badly dressed semi-tramps sitting on town halls steps with nothing to do all day. Every now and then there will be a serious untoward incident (a homicide committed by a psychotic man who has fallen through the net, and colourfully reported in the press), and overworked CPNs will be lambasted for not organising their paperwork properly.

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Because amidst this declining clinical capacity, the ability of the central bureaucracy to continue to make inappropriate demands on clinical time is astonishing. Recently we were advised that we should cancel clinics in order to fill out a series of forms relating to the 'Clusters' to fit outpatients into, as part of the costing exercise. In psychiatric terms these range from Care Cluster 1 (common mental health problems, low severity) to Care Cluster 21 (Cognitive impairment or dementia/ high physical engagement). In-between our range of terms includes 'enduring non-psychotic disorders/ high disability', and 'psychotic crisis'. Hundreds of patients had to be re-evaluated, costing hours of consultant time, as well as CPN and social worker time, to no particular clinical purpose. And this is just another in a remorseless, acronym – heavy demand for information to send up the chain of commands to the chateau known as the Department of Health. We have had Honos PBR, we have had C-QUIN, we have various traffic light indices in terms of length of stay, 7 day follow ups, dealing with the computer system 'Rio', and the average Care Programme Approach (CPA) and Needs Assessment form takes 3 or 4 hours to fill in.

There would have been some joy if the beginning of any kind of cuts in the health service, particularly in the psychiatric field, had started at the top. The less people there are in offices asking those in the clinical area to do things, the more time clinicians will have to see patients and even treat them. Within the LANSLEY bill there were bits and pieces of an understanding that an over-centralist NHS has become fossilized in its organisational structures, that there is too much inappropriate planning (which usually doesn't work out) and that there are too many hospitals. Unfortunately as we know the need to cost everything bumps up the rate of everything and we are marching towards American-style administrative costs. If secretaries cannot type letters because they are doing administrative tasks, (for example filling out C-QUIN forms or CPA forms) and doctors can't see patients because they are doing the same thing and nurses and social workers are trapped in front of their computers, what is it all about? 'Every data entered is a kindness foregone', is a quote from an anonymous author, and performance – managed enforcement of the privatisation of the health service is very bad for your health.

TREVOR TURNER

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## Meeting with the Shadow Health Secretary on 13th September 2011

Wendy Savage, Harry Keen and I, representing respectively KONP, the NHS Support Federation and NHSCA, met John Healey MP in Portcullis House.

There were two main topics, the Health and Social Care Bill and the need for the Opposition to develop and promote a positive alternative for the future of the NHS.

Not surprisingly, there was agreement that the Bill must be opposed. We described what our organizations were doing and in particular explained that the recent change of BMA policy to a demand for withdrawal owed much to NHSCA members within BMA Council. Attention was also drawn to the NHSCA initiative of an open letter with multiple signatories, featured in the national press, calling on the Presidents of the Colleges to do likewise.

Mr Healey was asked what the Labour Party was doing other than parliamentary opposition and he responded by describing the joint LP/ TU campaigns set up in a number of areas. Following our comments that these had received little publicity he told us that they had been given some

limited coverage by the national media but had been well attended in their localities and reported by the local press.

He confirmed that Labour MPs representing constituencies in Scotland and Wales had all used their votes against the Bill as had Plaid Cymru, and most Northern Irish MPs, only the SNP abstaining. He showed much interest in further information on Scottish post-market experience

Attention had now passed to the House of Lords and earlier advice to us was confirmed, that the Lords could set up a Committee to give detailed scrutiny to the Bill and efforts should be channeled to secure this outcome which would greatly slow its passage through that House.

We asked how he regarded the way in which the Bill was being implemented in advance of parliamentary approval. He agreed with our view that this was undemocratic and liable to cause problems but said that, by parliamentary convention, once a Bill had passed second reading a government was entitled to use funds to set up structures on the assumption that it would eventually become law.

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However we agreed that the argument that things had gone too far to turn back was not acceptable.

Moving on to the longer term, we insisted that the Opposition should not limit its activities to fighting current government policy but must without delay set out a positive alternative. His attention was drawn to the April 2010 joint BMA/Unions/Colleges/NHSCA etc Roundtable Meeting and Report "An NHS Beyond the Market". A number of examples were given of previous successful and acceptable innovative ventures deserving to be revisited, like the Resource Management Initiative of the mid-'80s/early '90s.

We pointed out that even if this Bill were to be defeated or withdrawn, the NHS would be vulnerable to further such attempts whilst the market structure remained in place and that the key to a return to NHS values was abolition of the Purchaser Provider Split.

This would mean acknowledging that time had shown some previous policies to have been mistaken but we referred him to the 1997 Labour Party Election manifesto statement (below) asking that this should now be reinstated as Party policy.

**"Our fundamental purpose is simple but hugely important: to restore the NHS as a public service working co-operatively for patients, not a commercial business driven by competition."**  
post-note: to which may be added the following from the same document: **"Labour will end the Conservatives' internal market in healthcare."**

Mr Healey described briefly the policy making process and was asked to ensure that the entirely different course being pursued in the rest of the UK was properly acknowledged and considered. He was given a brief account of the encouraging evidence emerging from Scotland and was left a copy of Matthew Dunnigan's provisional statistical analysis. He was also given a copy of the dossier which had been sent to selected MPs.

WDS mentioned the email she had sent him in August, as a Labour Party member, suggesting Labour put forward alternatives to the Bill. In his reply he had said that they were beginning to work on alternatives now.

We also discussed with him the way in which attempts to modify the current Bill had only served to make it more complex and bureaucratic and advised that simplicity should be the guiding principle, both for cost effectiveness and greater satisfaction for both patients and staff.

The meeting was conducted in an informal and friendly manner, ran over the allotted time and left us with the feeling that a channel had probably been opened for future use.

**PETER FISHER**

*This meeting has of course been somewhat overtaken by events. We have requested a meeting with Andy Burnham but have not so far been given a date. We are pursuing this urgently through various channels, particularly in view of his reported promises:-*

See on NHSCA website under "News"

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## NHS Reform

Do we really feel that this is the right time to be putting our medical house(s) in order?

Houses are very much in the news. The Upper House is engaged with vital Bill amendments, Cameron has made his pathetic plea for houses to be kept warm as the implied responsibility of the six major energy suppliers, and the Dale Farm travellers have at last moved on to find new homes. We, the elderly well-off, are facing subtle psychological pressures to look dispassionately at our homes and life styles by yet another organisation purporting to care for our Big Society and its responsibilities.

A new "Intergenerational Foundation" (who on earth thinks up such names?) wants us all to move out of our palatial multi-bedroomed establishments into little boxes (not the six-foot ones I trust) or into nursing homes presumably and thereby make way for our deprived homeless younger generation. Well,

this Foundation, like another dangerous Foundation we all know about, and certainly don't trust, needs nipping in the bud straight away.

How dare they worry those such as our hard-working President and his Hill House abode, with its endless corridors, bedrooms and hidden loos —why the very survival of our precious organisation could be threatened—and where do those of us who seek vital escape from our spouses to write about the NHS go to hide except into our superfluous bedrooms?

No, don't worry Morris, I haven't forgotten my title, "NHS Reforms", nor the question posed in the subtitle, nor is it a coincidence that the "houses" theme is a continuation of that posed in my September Editorial and that suggestions for reform have been made by various contributors. We may have set you thinking, I hope, about what could and should be reformed. You may not agree with what has been suggested.

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But let's remind ourselves why Lansley maintains there must be reforms, even if we are alarmed at the extent of proposals set out in the Bill and, not without good reason, doubt and suspect his true motives -- "the size of the challenges for our NHS of the future -- the increased demand on services, an ageing population and rising costs of new drugs and treatments--should not be underestimated, particularly when considered alongside the current financial challenges facing this country"

Surely, a reasonable enough argument based on fact? And, it could be reasoned, a sober enough template which all disciplines concerned about good health care, but particularly hospital-based clinicians (and dare I say it, again, nurse colleagues working alongside) should accept and use as a starting point for constructive debate? But can we allow ourselves to make a start, or are we so locked into a life or death battle over the Bill, that we dare not let go and look beyond, especially at areas where there could be and possibly should be reforms which could save vital finances, but importantly, not impact negatively on the quality of life of groups and individuals under our care?

Of course there are moral issues to be addressed, which conflict with the urge, and some would argue, with the right, to make available any advance in medical and surgical procedure or pharmaceutical breakthrough, to all, without the need to "own" consideration of issues of quality of life or cost.

Examples of concerns over "increased demands on service", and the moral dilemmas facing those taxed with making difficult decisions, were given in the September Newsletter by Andrew Porter, paediatrician colleague, and his reflections on "the humanitarian and financial costs involved in the intensive care of extremely premature infants, below 28 weeks gestation, or those with recognisable severe brain damage at a later gestational age--There is a danger of treating barely viable infants because you can, not because you ought."

The same author, as guest editor in an earlier Newsletter (December 2010) makes timely reference to the second and third government concerns, namely our ageing population and the rising cost of new drugs and treatments. His reference to the RAND corporation statistic on the disproportionate healthcare expenditure spent on average in the last six months of life, whenever that occurs, leads him to suggest that "the answer may lie in reducing expensive interventionist methods, often undignified and painful, when there is no prospect of appreciable gain in QALYS". This excellent editorial, well worth revisiting on the subject of economies, quotes Prof. Richard Lachman (BMJ 16/10/10) on how savings could be made in developing new drugs and also in making better use of expensive medical facilities. There is one important omission from the often quoted Lansley argument of what needs to be done in

reforming the NHS, namely the wholesale reduction of tiers of Management, with the implication that they hinder medical colleagues in functioning efficiently and could readily be removed without detriment to running of the hospital service and with a substantial financial saving also. Despite repeated attempts by our organisation to explain to successive governments that the purchaser-provider model is at the root of the financial problem and the need for such top-heavy management, the advice falls on deaf ears.

But allow me to ask the important question. Do we believe, as I have asked earlier, that the main target of our continuing campaign for NHS reform should be government and the P-P split, and that to engage with them over the issues outlined by Lansley above would be premature and politically unwise?

If so, by all means let's hang on 'till later (as they say in my part of the world), but I'm still puzzled by the inevitable cryptic concession volunteered by everyone who speaks or writes opposing the health Bill that "yes, there have to be reforms". But I shall not be a great deal wiser about what they have in mind unless they are prepared to say a little more.

Finally, what of official government bodies such as the Health Ombudsman, the Dr. Foster organisation and CQC? Should we take their findings and recommendations seriously? And are they up to the task of contributing to NHS Reform?

Well, yes, provided they are transparent and that we are allowed access to details of their membership, their expertise, numbers and powers and how these are used, and provided we have a right to debate their findings and recommendations from the reports they produce. Healthwatch (England), the successor to NALM, would be the obvious watchdog and arbiter under the proposed Bill, but amendments need to be agreed still to allow this to happen, with CQC given oversight of Healthwatch.

The CQC is seen by government as having an increasingly important regulatory role with stronger enforcement powers in place since April 2010, including powers to close units and even whole Hospitals using sixteen standards of performance, but it's history does not altogether reassure some Trust managers and even more importantly, some patient groups that assessment processes are meaningful. Self-assessment box-ticking, too much emphasis on financial performance and insufficient attention to quality of care have featured in past criticisms. Also, for some, the ghost of the Mid-staffs disclosures live on to haunt the CQC, with it's CEO, Cynthia Bower at it's head having stubbornly resisted calls for her resignation as CEO of Mid-staffs when facing major relatives concerns about standards of care.

**GEOFFREY MITCHELL,  
BEVERLEY**

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# CHAVS: The Demonization of the Working Class

Owen Jones (Verso 2011 £14.99)

This review aims to summarize the key points of CHAVS: The Demonization of the Working Class. The book has relevance to the work of most clinicians insofar as they have working class patients and colleagues. The paperback discusses in clear prose some of the major changes that have been occurring in Britain over the last fifty years or so. To the many who are allergic to the jargon of some sociologists, I hasten to add that Owen Jones is a historian rather than a social scientist. (He is now a writer and broadcaster but was previously a parliamentary researcher for a trade union.) I quote the author freely so that you can judge for yourself the style and approach.

Had you come across the word *chav* before you saw it here? The word first appeared in the Collins English Dictionary in 2005 – “a young working-class person who dresses in casual sports clothing.” Since then, the meaning has broadened considerably. Jones says it is a myth that the word is an acronym for Council Housed And Violent.

Jones suggests that nowadays the term *chav* “encompasses any negative traits associated with working class people – violence, laziness, teenage pregnancies, racism, drunkenness, and the rest.” It is synonymous with ‘prole’ and any word or phrase meaning “poor and therefore worthless.” The word is also synonymous with white working class. Jones suggests that the broader term ‘working class’ became a “taboo concept in the aftermath of Thatcherism.”

Jones explains that ‘*chav*’ goes deeper than inequality. “At the root of the demonization of working-class people is the legacy of a very British class war. Margaret Thatcher’s assumption of power in 1979 marked the beginning of an all-out assault on the pillars of working-class Britain. Its institutions, like trade unions and council housing, were dismantled; its industries, from manufacturing to mining, were trashed; its communities were, in some cases, shattered, never to recover; and its values, like solidarity and collective aspiration, were swept away in favour of rugged individualism. Stripped of their power and no longer seen as a proud identity, the working class was increasingly sneered at, belittled and scapegoated. These ideas have caught on, in part, because of the eviction of working-class people from the world of the media and politics.”

“Politicians, particularly in the Labour Party, once spoke of improving the conditions of working-class people. But today’s consensus is all about escaping the working class...”

“At the heart of the ‘chavs’ phenomenon is an attempt to obscure the reality of the working-class majority.

‘We’re all middle class now’ runs the popular mantra – all except for a feckless, recalcitrant rump of the old working class.”

Serving as two case studies, Jones examines the different ways that the media dealt with the disappearance of two girls - Madeleine McCann (middle class family) and that of Shannon Matthews (working class family). An important aspect of the different media treatments was the ways that journalists tended to stress ‘welfare fraud’ (which the Treasury estimates to cost £1 billion a year). Tax evasion is estimated to cost £70 billion a year.

The growth of inequality is described. For instance, the Gini coefficient in Britain (a measure of overall income inequality) has risen from 26 in 1979 to 39 now. Jones discusses the changes in employment, particularly in relation to manufacturing, and concludes that “industry has been stripped from Britain because of government policy, not because of the onward march of history. No other West European nation saw the obliteration of manufacturing in such a brutally short period. Just consider the contrast with the response to the financial crisis that exploded in 2008. While Thatcherism left manufacturing to bleed to death in the 1980s, the New Labour government pumped billions of pounds of taxpayers’ money into banks whose greed and stupidity had left them teetering on the edge of collapse.”

As well as describing the trends and vulnerability in employment, particularly the growth in part-time and agency jobs, Jones contrasts the small size of union membership now with what it was when industry such as mining was strong. In 1979 union membership was thirteen million, now it is just over seven million. “Nearly two thirds of the nation’s wealth went on wages back in 1973. Today, it’s only a little over half.” It is not just the legacy of Thatcherism that workers have to thank for their stagnating pay, “globalization has played a role too.”

A chapter in the middle of the book is entitled ‘We’re all middle class now’ and the quotation at the head of the chapter is from Nick Cohen, the Observer columnist: “To say that class doesn’t matter in Britain is like saying that wine doesn’t matter in France; or whether you’re a man or woman in Saudi Arabia.” The thrust of the chapter is to demolish the view that we are all middle class now. One kind of strong evidence comes from opinion polls that stubbornly show that more people in Britain call themselves working class than did in 1950. Over half the population consistently describes itself as working class.

The concluding chapter of the book is constructive and well argued in relation to the preceding analysis.

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Throughout the book there are relevant and often powerful quotations from the broadly-based interviews that Jones conducted.

The aim of the book is “to expose the demonization of working-class people; but it does not set out to demonize the middle class. We are all prisoners of our class. But that does not mean we have to be prisoners of our class prejudices. Similarly, it does not seek to idolize or glorify the working class. What it proposes

is to show some of the reality of the working-class majority that has been airbrushed out of existence in favour of the ‘chav’ caricature...Ultimately, it is not the prejudice we need to tackle; it is the fountain from which it springs.” I think the author achieves his aim impressively – the book is not only ‘a good read’, it is nourishing. It would make a great present for a thoughtful relative or friend.

PETER DRAPER

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## Meeting with Shirley Williams

Shirley Williams’ base is at Fielden House which is near the Houses of Parliament. Wendy and I met her there on 1st November following email correspondence SW had had with Andrea Franks. Half an hour had been allocated, but the meeting ran on for about 50 minutes. Most of the communication was between Wendy and SW, not least because of my cursory familiarity with the Health and Social Care Bill. At the time of our meeting there were 350 amendments to the bill which were to be considered by the Lords over 18-20 days.

In respect of Wendy’s suggestion that the bill be scrapped, SW said there was no chance of this happening in the Lords. The Commons would simply return the bill and it would be pushed through. SW thought it better to get the Tories to consent to amendments. She understood why there was extra-parliamentary pressure for change.

Clause 1 of the bill absolves the Secretary of State from a constitutional duty to be responsible for the performance of the NHS. The intent is to hand this responsibility to the National Commissioning Board and Clinical Commissioning Groups (CCGs). SW’s amendment to Clause 1 was explicit in mentioning the Secretary of State’s duty to provide for the physical and mental health needs of the population. However Lord MacKay who was on the Constitution Committee had then provided his own amendment to Clause 1 which specified only a limited set of circumstances for which Lansley would be directly responsible. Wendy wanted to know if SW’s amendment would be voted on the following evening (bearing in mind that SW had abstained from the Lords vote on the Owen amendment). SW stated that the position was extremely fluid and that at that time there were almost hourly events which impinged on the matter. In particular Clause 1 had to be linked to Clauses 4 and 10 which dealt with promoting autonomy for health service providers and CCGs respectively. Clauses 4 and 10 were themselves subject to amendments.

SW explained why the voting for the Hennessy-Owen amendment had had such poor support. This amendment called for a select committee to consider the constitutional and other problematic aspects of the bill and this would have delayed the passage of the bill in the Lords until at least January. Some hoped that

such a delay would result in the bill running out of time and thereby die, though Owen was explicit that he had not intended this. SW asked: “Who would appoint the members of the committee”? The answer is the Whips Office which SW stated would result in the appointment of individuals sympathetic to the bill. In fact many Lords, particularly those with a medical background, wished to participate in the proceedings hence the low vote for the Hennessy-Owen amendment.

Wendy pointed out the risk to integration of services. SW stated that amendments would put the emphasis on collaboration rather than competition for CCGs and that Monitor’s primary function would be the care of patients rather than competition. Integration features in many of the amendments and SW thought there might be a greater emphasis on integration of services because of the bill than was the case before the bill.

Payments to CCGs would not allow individuals to make a profit and any extra money would have to be ploughed back into the service. An amendment put a cap on Foundation Trusts’ earnings from private patients. Because a regional function was in fact necessary, SW said that SHAs would be retained albeit under a different name. An amendment would require the secretary of state to intervene if a service was in financial difficulty rather than become involved only at its demise as the bill specified. Every CCG would have public health representation.

Lord Newton of Braintree is a Tory who is against the bill. Brian Mawhinney has changed tack and made a good speech. Cameron and Lansley have their differences about the bill. Cameron and Lord Walton had had a meeting with Lansley about concerns that Cameron had had. If the MacKay amendment is passed Lansley might yet change Clause 1 back to its original wording.

SW pointed out that the effect of the bill would be evaluated by comparisons on performance indicators of Scotland versus England.

SW was hopeful that amendments would undermine the more harmful elements of the bill.

NOTES BY MORRIS BERNADT

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# The Roy Lilley Blog

Mr Roy Lilley writes regular blogs about the health service on [nhsmanagers.net](http://nhsmanagers.net),

In some of these he sounds radical in his criticism of the new Health and Social Care Bill, which he says is too complicated.

However, he has come out in his true colours over the issue of NHS hospitals.

In his blog "Same old, same old" 31st October 2011-11-06, he compared Andrew Lansley to Frank Dobson, claiming both found a way to keep NHS hospitals going.

This comparison is ridiculous. Lansley is pushing through a Bill, which will result in mass hospital "failures" on the basis that they are not "financially viable" - meaning do not produce a surplus as separate businesses, - and will not qualify for Foundation Trust (FT) status, which is a must under the Bill.

He threatened trust managers with dismissal if they did not achieve FT status on time. ("Lansley to 'remove' NHS managers who don't meet foundation hospital deadline". Guardian 26.10.2011)

Lilley ended his blog with the words; "We all know we've got too many hospitals, often badly run, in the wrong places. No one is brave enough to do anything about it."

This is the message being pumped out in the media, ad nauseam, by the government, the DH, the King's Fund, former Blair advisers, the NHS Confederation employers organisation and Prof. Steve Field and the Future Forum. Lilley now joins this prestigious list of the great and the good advising the government to make the QIPP cuts to re invest in the private sector and close down the District General Hospitals (DGHs).

But he has now stepped up his attack in a new article "Forget the health bill. NHS, meet Tesco." "The health service needs to learn lessons on locating its services from supermarkets." (Guardian professional. 3.11.2011.)

His key messages are;

## **1. The most important thing is to save £20bn by 2015. (McKinsey QIPP cuts AA)**

"and the big money is in the wholesale reconfiguration that gives MPs a heart attack."

**2. This must be done by ending DGHs (He does not name DGHs but we know he is referring to them as he says they are doing the wrong thing. He does not want them to provide A&E and emergency care and wishes them to give up the rest of their services. This dismantling of the DGHs and shifting the care out of hospital, he calls "Reconfiguring the healthcare model.")**

\* His justification for this is that;

- there are too many of them
- they are in the wrong place
- they are badly managed
- doing the wrong thing.

## **3. Welcome to the business model.**

"The NHS is edging towards a business model" ... so therefore ... "using the techniques of business may not be such a bad thing."

For him, the question of who provides the service is "philosophical". "Philosophical debates about the private sector waste time." So, he is just fine with the NHS being privately provided and run for profit.

**4. Closure of A&Es upset people who then protest. But this is silly, because it is really in their best interests to have larger hospital miles from their homes.**

He says, to prove this we can compare A&Es departments to high street grocery stores. People don't like the latter closing. But it is really much better for them to have a Tesco superstore out of town.

- because the parking is free
- it puts all the good stuff in one accessible place.
- This is "centring excellence"

One can only assume he is referring to tertiary and teaching hospitals, when he talks of Superstores out of town. Of course, tertiary and teaching hospitals are excellent. But they can only stay that way, if they are allowed to concentrate on the difficult complex work, that only they can do and have the staff for. Of course we need them for heart surgery, and severe trauma, burns and the like.

There is no advantage in them being flooded with patients requiring the common emergency operations such as appendicectomies, or perianal abscess drainages, or cholecystectomies, ectopic pregnancies and missed abortions, fractured ankles and hips or acute medical conditions such

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as pneumonias, exacerbations of CCF and COPD, jaundice, and all the other host of medical and surgical conditions which are perfectly well cared for in DGHs.

The DGHs in fact do put 97% of the good stuff in one accessible place, which is why patients love and respect them and fight like blazes to keep them.

##### **5. Bring back the polyclinics (though this word is not used).**

He summarises this “ The NHS must do the same thing: out of town super hospitals and the equivalent of Tesco’s corner shops- NHS-extra- locally.”

He says “The ‘NHS-extra’ Darzi centres were the future”.

This argument is not new, it was used by Ruth Carnall, CE of NHS London, in support of the Darzi plan to close many of London’s DGHs. “ (‘Tesco Metro-style NHS will cut £5bn’ Evening Standard 25.11.09)

Polyclinics cannot do what DGHs do. They are GP or nurse led, with the occasional consultant visit. They do not have 24 hour Xray/ CT scan radiologist back up, or 24 hours path labs and operating theatres. They have no junior staff and no in-patient beds.

##### **6. GP surgeries are out of date, too small, not safe, and “cannot cope with the volume of care we plan to transfer out of hospitals.”**

First this is an attack on traditional GP care. Second, one can only assume that he wants to transfer out of DGHs everything that Darzi wanted to move out; those patients who carry least serious clinical or financial risk; the young and fit, the short stay elective surgery and endoscopy, and rehabilitation care. His coded message is that the private sector want this work in large profit making GP led health centres called “ NHS- extra” and presumably ISTC like structures.

##### **7. What is needed is “Vertical integration, with secondary care owning primary care.” He compares this to retailing.**

So nothing has changed then. All the talk of integration, leads us back to the Health Maintenance model of Kaiser Permanente, so much beloved of Prof Chris Ham and colleagues at the Kings Fund. Here, the company selects patients for health insurance and employs its own staff to provide primary and secondary care, reducing the latter to keep costs down.

The Health Bill, forces all hospitals to become FT businesses, and allows Clinical Care Groups to be

owned by FTs. Both of these can be bought up/ taken over by private sector companies and be run as vertically integrated businesses.

What we had in the NHS as founded and still have in Scotland, was complete public sector integration; funding, planning, and provision all in one national organisation. No transaction costs, no billing and cheating, no tariffs, no burgeoning management structures and commissioning costs, no PFI.

What the author wants is vertically integrated private sector organisations of Tesco style magnitude, such as UnitedHealth, Assura Medical/ Virgin and the rest, competing for NHS contracts in huge public-private partnerships, so that these corporations can carve up the market between them and fix prices and make super profits like the Health corporations do in the US. Monitor? Well, just think on the profits of the big energy companies despite their so-called regulation.

##### **8. Services will SHIFT out of hospitals.**

And if this happens he proposes that these half empty hospitals should not be closed! The evacuated beds in these wards should be leased to private operators, who could run on them on behalf of the NHS to care for the elderly!

Brilliant. The care of the elderly would be outsourced to these private companies. And because the hospital buildings would still be owned by the NHS, the private companies would not have to take responsibility for what he calls “ the property cost risks” i.e. the PFI debts/ or buildings leased out to raise loans.

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Here we have in more sophisticated form all the same old arguments for privatising the NHS. Central to this plan is the demolition of our DGHs, which provide locally accessible high quality consultant-led all-round care. The DGH brings together the main medical specialties, including elective and emergency care, so that all the different aspects of a patient’s care can be addressed on one site.

The fight against the £20bn McKinsey cuts, to keep hospitals open and defend frontline jobs IS the fight to stop the NHS being privatised. The unions should be leading this fight. Not dragging their feet. Every DGH must be defended.

We need national joint action by the unions to get rid of this privatising government. Lets hope the action on Nov 30th is the start. Please support the march and rally to occupy Chase Farm hospital to keep it open on Sat, 10th December. 1pm The Green Enfield.

ANNA ATHOW

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# Integrated Care - What Does it Mean for the NHS?

## Editorial Comment

We are pleased to have in our Newsletter Chris Ham's paper on integrated care which he has prepared in response to our invitation to contribute. The paper defines his interpretation of what integrated care is and his views on how its components might be organised. At the macro level Ham's paper has largely American examples whereas at the meso level there is interesting comment on experience in Torbay. Our Newsletter welcomes constructive debate about controversial issues; one such is the standing of the Kaiser-Permanente HMO. In respect of its ratings of patient satisfaction and clinical quality, our members might well have information and interpretations differing from those reported in Prof Ham's paper. The methodological problems of the 2002 Lancet paper are well known and include the fact that Kaiser-Permanente mostly covers a population of the working well.

We anticipate further debate in the March Newsletter.

**MORRIS BERNADT & TREVOR TURNER**  
Guest Editors

The aim of this paper is to describe the different forms of integrated care and to summarise evidence on their impact. The paper is based on a major review published by The King's Fund (Curry and Ham 2010) and has been prepared in the light of the increased interest in integrated care arising out of the work of the NHS Future Forum and the government's response.

## What is integrated care?

Integrated care takes many different forms. In some circumstances, integration may focus on primary and secondary care, and in others it may involve health and social care. A distinction can be drawn between real integration, in which organisations merge their services, and virtual integration, in which providers work together through networks and alliances.

Both real and virtual integration may take place between providers operating at the same level, often referred to as horizontal integration, and between providers working at different levels, known as vertical integration. In many cases, integrated care involves providers collaborating, but it may also

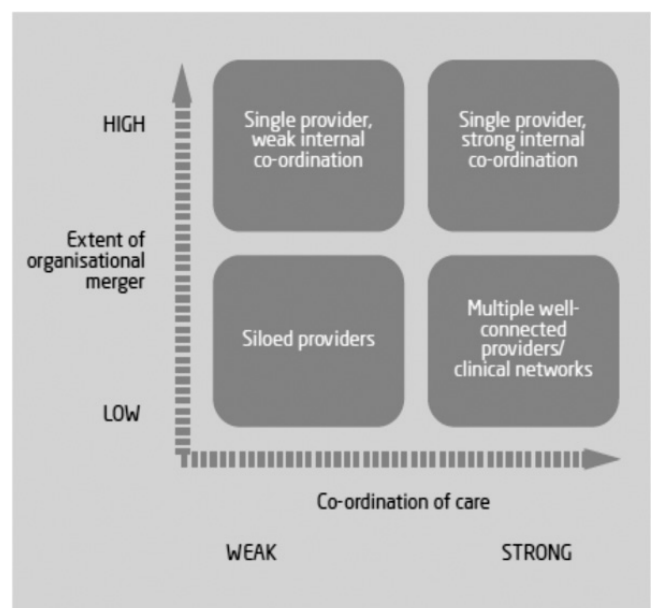
entail integration between commissioners, as when budgets are pooled.

The most complex forms of integrated care bring together responsibility for commissioning and provision. When this happens, clinicians and managers are able to use budgets either to provide more services directly or to commission these services from others: so-called 'make or buy' decisions.

## The limits to organisational integration

Evidence indicates that organisational integration will not deliver benefits if clinicians do not change the way they work. An alternative to organisational integration is to find ways of enabling organisations to co-ordinate their work more effectively. This is particularly relevant to the NHS in England, where health and social care are commissioned and provided by a wide range of organisations. The challenge will be to support the development of networks between these organisations and virtual or contractual integration where appropriate.

The accompanying figure below illustrates the range of options available to health and social care organisations:



## The three levels of integration

In our review of the evidence on integration, we drew a distinction between integration at three levels:

- the macro level at which providers, either together or with commissioners, deliver integrated care across the full spectrum of services to the populations they serve
- the meso level at which providers, either together or with commissioners, deliver integrated care for a particular care group of people with the same disease or conditions
- the micro level at which providers, either together or with commissioners, deliver integrated care for individual service users and their carers

### **Integrated care at the macro level**

#### *Kaiser Permanente*

Kaiser Permanente is the largest non-profit-making health maintenance organisation in the United States, serving 8.7 million people in eight regions. It is a virtually integrated system in which the health plans, hospitals and medical groups in each region are distinct organisations linked through contracts. Kaiser Permanente is recognised as one of the top-performing systems in the United States with high levels of member satisfaction and excellent ratings for clinical quality. It is also one of the lowest-cost providers in most of the regions in which it operates. President Obama has described Kaiser Permanente as a high-quality, cost-efficient provider that serves as a model for the rest of the United States.

#### *Impact*

Studies that have compared the NHS with Kaiser Permanente show that the NHS uses around three times as many bed days for older people with common conditions like hip fracture and stroke as Kaiser Permanente. Part of the explanation is that, compared with the NHS, Kaiser Permanente delivers more care out of hospital in large medical offices (analogous to polyclinics) and it also makes use of step-down facilities. A key feature of the Kaiser Permanente model is the emphasis placed on keeping members healthy and achieving close co-ordination of care through the use of the electronic medical record and team working.

#### *The Veterans Health Administration*

The Veterans Health Administration (VA) is an example of real integration in that it employs doctors, owns and runs hospitals and medical offices, and manages the full range of care within a budget allocated by the federal government. Although the VA is now recognised as a leader in the provision of high-quality care, this has not always been the case. In the mid-1990s it was seen as an inefficient bureaucracy delivering mediocre care, and it was only following the appointment of a new leader that its performance was transformed.

The transformation of the VA was based on its reorganisation into a series of regionally based, integrated service networks in place of the fragmented hospital-centred system that existed previously. Each network provides the full spectrum of care and is funded on a capitation basis. Network managers are held to account via a rigorous performance management system centred on clinical quality and outcomes. Like Kaiser Permanente, the VA has invested in IT and makes use of an electronic medical record.

#### *Impact*

Studies have shown that the shift to integrated service networks resulted in a 55 per cent reduction in bed day use and improvements in quality of care. There were also increases in visits to primary care and home care services. The VA has pioneered the use of telehealth, and this has contributed to the emphasis on care in the home and reduced use of hospital and long-term care beds.

#### *Integrated medical groups*

Integrated medical groups, also referred to as multispecialty medical groups, are composed of doctors from a number of specialties who may be directly employed by an integrated system (as in the VA), have an exclusive relationship with such a system (as in Kaiser Permanente), or take on a budget with which to provide and commission all or some of the services required by the populations served. The degree of integration within groups varies from those that are loose alliances of practices that come together in independent practice associations, to tightly organised groups based on a common culture and set of values. There are currently around 210 multispecialty groups with 50 or more doctors, some of whom have developed alliances with hospitals.

#### *Impact*

Studies have shown that medical groups working under capitated budgets in the 1990s reduced the use of hospital services both by avoiding inappropriate admissions and by cutting lengths of stay. They did so by requiring prior authorisation of referrals, using case management programmes and appointing hospitalists to take care of patients in hospitals. Recent research has shown the benefits of large integrated medical groups, including the use of electronic medical records, involvement in quality improvement, and the provision of preventive care. The caution about integrated medical groups is that many ran into difficulty when financial constraints increased and only those groups with effective leadership and management support were able to weather the storm.

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## Integrated care at the meso level

Integration of care at the meso level focuses on care for particular groups of patients and populations, whether they are classified by age, condition or some other characteristic. Many of the examples of integration at this level are concerned with the needs of older people because of the challenges that this group presents in terms of their high utilisation of services and the risk that fragmented care will deliver poor outcomes. There are also examples of integrated care for people with long-term conditions as well as the use of 'chains of care' in Sweden and managed clinical networks in Scotland.

### *Care for older people*

Examples of integrated care for older people that have been subject to evaluation include the North American Programme for All-inclusive Care for the Elderly (PACE), Integrated Services for Frail Elders (SIPA) and PRISMA programmes in Quebec, and three European examples: Rovereto, Vittorio Veneto and Torbay. While each example has some specific characteristics, they share a concern to enable frail older people to remain independent and to avoid the use of nursing homes and hospitals wherever appropriate. Studies have shown a range of benefits including improved health outcomes for older people, reduced utilisation of nursing homes and hospitals, and some evidence of cost savings.

Experience in Torbay illustrates how these benefits have been realised in the NHS. Starting from recognition that health and social care services for older people were often fragmented, leaders in Torbay established an integrated health and social care team in Brixham to serve a population of 23,000 people. The team brought together expertise from adult social care and community health services and was co-located under a single manager at the local community hospital. The team worked closely with general practices in Brixham to identify and support older people at risk of admission to hospital.

Integrated teams were subsequently established in four other localities and were given control over pooled health and social care budgets. These budgets were used to increase the provision of intermediate care to support people to remain independent and to enable a rapid response to be made to their needs. Experience in Torbay showed the critical importance of health and social care co-ordinators within the integrated teams. Co-ordinators are not trained professionals and their role is to work closely with professional staff and managers to provide the right care in the right place at the right time. Teams are now able to access information about patients and service users from the integrated information systems that have been established.

Having focused initially on creating integrated teams and aligning their work with general practices, the primary care trust and local authority agreed to merge their functions by creating a care trust. This was done in 2005 and provided a platform on which to build on and extend early achievements.

### *Impact*

Studies have shown that as a result of integration Torbay has reduced the use of hospital beds, achieved very low delayed transfers of care from the hospital to the community, and it has rates of emergency admissions and re-admissions to acute hospitals that are much lower than in areas with a similar demographic profile. There have also been reductions in the use of residential care, increases in the use of home care, and there are high rates of use of direct payments in social care. The performance of adult social care has improved from a low base as a result of integration.

### *Long-term conditions*

There are examples in many different countries of integrated care focused on the needs of people with specific long-term conditions such as diabetes, heart failure and chronic obstructive pulmonary disease. Disease management, as it is sometimes known, has been taken forward in the United States and more recently Germany as well as in the NHS in order to tackle fragmentation between different providers. A variety of approaches have been adopted with the aim of offering a co-ordinated approach that combines patient education and self-management support, care planning, and primary and specialist care.

### *Impact*

The diversity of approaches means that it is difficult to provide an overall assessment of the impact of disease management. Studies have shown some benefits in relation to reduced use of hospitals, especially for emergency admissions, processes of care and patient satisfaction. However, evidence on cost effectiveness and cost savings is often lacking or inconclusive. Despite these caveats, there continues to be interest in the use of disease management for people with long-term conditions, both for people with single conditions and for those with more complex needs where different forms of case management have been used.

### *Chains of care and managed clinical networks*

A common way to co-ordinate and integrate care for patients and populations with specific conditions has been to establish care pathways and networks. This approach has been developed in Sweden and is known as chains of care. A chain of care seeks to meet the needs of patients with a certain condition by linking primary care, hospital care and

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community care through care pathways, based on local agreements between providers.

Similar in some ways to chains of care, managed clinical networks have been established in Scotland to strengthen co-ordination of care between organisations and clinicians. Managed clinical networks were conceived on a number of scales (from local to regional to national) and with a range of scopes – for people with a particular condition (eg, diabetes), across various specialties (eg, neurology) and for particular functions (eg, emergency care). These networks do not require the creation of new organisational entities or physical facilities but rather they seek to broker care across providers in a form of virtual integration.

#### *Impact*

Studies have shown that chains of care have had limited impact and they underline the challenges involved in overcoming professional and organisational barriers to integrated care. Evidence on managed clinical networks is more mixed with some evidence of benefits albeit with variations between networks. A recent study of partnership arrangements in the Scottish NHS - often seen as a counterpoint to arrangements in England with its emphasis on the commissioner/provider split and the use of competition - was similarly cautious about the impact of these arrangements.

There is more positive evidence from experience in England with the establishment of specialist networks for stroke care. These networks concentrate specialist care in fewer units able to offer the best possible care and ambulances transport patients direct to these units where appropriate. In London early results suggest that 400 lives a year are being saved by the reconfiguration of stroke services.

#### **Integrated care at the micro level**

Integration of care at the micro level is concerned with the co-ordination of care for individual patients and carers. Many health care systems assign responsibility for care co-ordination to a specific individual or team, often general practitioners and others working in primary care. In recognition that much co-ordination activity is not medical, these systems also employ co-ordinators from nursing and other backgrounds, as in the example of health and social care co-ordinators in Torbay described earlier.

The tools of care co-ordination are many and varied and include:

- the use of care plans and care planning, as in the Care Programme Approach for people with mental health problems
- the use of case managers as in the Evercare programme and related initiatives
- the use of virtual wards in which integrated teams, often including case managers, support patients with complex needs living in the community
- the use of personal health budgets and direct payments to enable patients and users to decide on the care they need
- the use of information technology, including the electronic medical record, to enable patients and professionals to access information
- the use of telehealth and telecare to support patients and users to live independently in the community

#### *Impact*

Many of these tools are used in the examples of integration at the macro and meso levels of care. Studies have shown mixed evidence of impact with a recent review suggesting that the use of multiple approaches to care co-ordination is more effective than approaches that rely on a single strategy.

#### **Lessons for the NHS**

This paper shows that integrated care takes many forms and has been pursued at different levels.

- Organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care, notwithstanding the achievements of integrated systems such as the Veterans Health Administration.
- Alternative approaches based on virtual or contractual integration, as in Kaiser Permanente, hold just as much promise because the benefits of integration arise primarily when clinical teams and services are brought together and incentives are aligned to support service improvement.
- Clinical commissioning groups can learn from the experience of integrated medical groups in the United States, including the challenge of managing budgets when finances become constrained.
- Health and social care integration for older people has been shown to reduce the use of hospitals and improve outcomes and the arguments for spreading examples of good practice, as in Torbay, are compelling.
- Disease management for people with long-term conditions also has potential, although the

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evidence is more mixed than in the case of older people.

- Clinical networks to improve outcomes in the provision of specialist care such as stroke services have shown promising results but further evaluation is needed.
- Integrated care for individual service users and carers designed to strengthen care coordination can bring benefits, especially when multiple approaches are used together.

### Where next?

The government's response to the report of the Future Forum indicates that integrated care will play an increasingly important part in the NHS in the future. The challenge now is to act on the evidence and to do so at scale. It is clear from the research summarised in this paper that there is no one 'best' way of delivering integrated care. The government should therefore avoid prescribing what should be done and should encourage a period of testing and evaluation of different approaches.

It is essential that social care as well as the NHS is involved in the work that is done and that active encouragement is given to the involvement of

the independent sector, including third sector organisations. As this happens, there would be value in allowing active experimentation with new ways of procuring and paying for integrated care, such as the use of lead providers who subcontract with others, and payment systems that go beyond the tariff to explore the use of capitated budgets and incentives for high-quality care. The role of clinical commissioning groups and the NHS Commissioning Board in commissioning integrated care will be particularly important.

Integrated care offers an opportunity to make a reality of care closer to home. In systems like Kaiser Permanente, acute hospitals are seen as cost centres rather than profit centres and incentives are aligned to support a focus on prevention, primary care and care in the community. The financial challenges facing the NHS require an urgent re-orientation in this direction to enable care to be delivered in appropriate and cost-effective settings.

Curry, N and Ham, C (2010), *Clinical and Service Integration: the route to improved outcomes*, London: The King's Fund

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