NHSCA

EDITORIAL September 2007

Reflections on a turbulent twelve months

It is just over a year ago that I was installed as President of the Royal College of Physicians and neither I, nor I suspect the other eight candidates who had stood for election, foresaw what would be the issues that would dominate the first twelve months of that term of office. Indeed there would have been many fewer candidates, I suspect, if we had anticipated the mayhem that would follow the radical changes in UK training. As *Hospital Doctor* and *The Times* asked what were the challenges facing me, Modernising Medical Careers (MMC) was certainly on the list of future uncertainties, alongside other issues like the future of academic medicine, the impact of the changes in the immigration laws and revalidation of specialists. I, like so many others, had concerns that there might be teething problems in the implementation of a brand-new training system, but these were vague and difficult to tie down amidst a Department of Health (DH) confidence that it had all been sorted out. And where were the voices of those who now claim they could see disaster coming a long way off?

It certainly behoves all of us to look back and learn lessons where we can. It is tempting for Colleges to fall back on the fact that the statutory responsibility for postgraduate training was removed in effect from them when the Postgraduate Medical Education and Training Board (PMETB) was set up as the competent authority to replace the Specialist Training Authority (STA). However that would be to deny their undoubted close involvement in what followed the Chief Medical Officer's initial report 'Unfinished Business' in 2002. Even in hindsight, there was much to support in the principles contained in that document – aims of improving SHO training through increasing flexibility, a more structured training environment and delayed career choice. It is not surprising that this report received much support from those with centuries of experience of training issues – the Royal Colleges – and ironic that much of what went wrong in MMC resulted in some opposite outcomes, namely reduced flexibility and forcing earlier career choice. It was the incremental creep in the changes to the original concepts, through further reports such as 'Modernising Medical Careers' and 'The Next Steps' that will no doubt be examined by the independent inquiry under the chairmanship of Sir John Tooke. In my view, many of the problems were the result of a fixation with 'run-through training', the selection into a career structure straight after Foundation training allowing progression through to a Certificate of Completion of Training (CCT), subject to competencies having been achieved but without a further step determined by open application and selection. There are several problems with this. One is that it forces early career selection – in effect within months of completing house officer posts and full registration – before either the individual is sure where their skills lie or those selecting can properly judge; this reduces flexibility to change career direction. Another is the reliance on the assessment of competencies as the sole means of judging suitability for progression; the tools for this are not fully developed, and while they may be adequate for 'ticking off' practical skills they do not encourage innovation and excellence in the way that open competition does. This does not mean that selection and run-through from Foundation years may not be appropriate for some

specialities, but there are no educational reasons for forcing it upon all.

And so why did Colleges and other bodies not stand up and point out these concerns in advance? Of course concerns were raised and improvements in training programmes achieved (for instance in Medicine we fought for and won a variation in run-through that allowed competitive entry in all but name into higher subspeciality training after a more generic basic medical training). Also, as ever, a public criticism of DH policy risked exclusion from further policy development. But in essence it was hard to see the wood for the trees, with confused governance arrangements for the project and with the DH determined to implement the radical changes in a 'big bang' – despite advice to the contrary – on an incredibly tight timescale.

So far I have not touched on the most public and emotive failure, that of the central application and selection system (MTAS) – in part because the Colleges were not involved in its evolution but also because there was destined to be a disaster even if the computer system had worked. This was because of the inherent mismatch between the numbers of applicants and training posts. The cause of this mismatch was several – the unanticipated numbers applying from career posts such as staff grade doctors, those from the European Union and finally the ten thousand or so non-EU nationals. This last group, on which the UK has relied so heavily over the years to maintain the National Health Service, had been in limbo ever since the immigration regulations were changed over a year ago but with no clear steer from Government as to whether they were 'out or in' MTAS. That said, it is truly remarkable that a system of such complexity as MTAS that was trying to cope with the lifelong aspirations of tens of thousands of young professional people, should use an anonymised system that gave little credit for previous achievements and was unpiloted. It was academic medicine that was disadvantaged most for several and complex reasons. Potential academics were often identified in advance by professorial units, and this ability to bring on the best gets lost in an anonymous system. Of course one aim of MTAS was to avoid unfair bias and nepotism, but again this can act against the promotion of excellence.

And so what of the way forward? There have been two groups set up by the Secretary of State in the wake of the debacle, one under the chairmanship of Professor Neil Douglas to deal with the immediate problems as best it could and the second chaired by Sir John Tooke to understand in more detail what went wrong and to advise for the future. Both will report about the time of this article going to press. The RCP, along with many others, has submitted detailed evidence and advice. If we are to learn lessons from the recent past, any changes in selection will have to be properly piloted, and so will not be available for 2008 – hence we must be prepared to accept interim solutions. It is essential, however, that such interim arrangements do not prejudice the implementation of selection methods and training programmes for the future that command the confidence of junior and senior doctors alike and that are appropriate for producing excellence in British medicine.

And what of other issues for the Royal Colleges in the future? One that will become more and more acute is the perennial one of medical workforce planning. Consultant expansion is slowing down just at the time that the increases in medical student numbers planned at the beginning of the decade are beginning to feed through. We need a clear view of the nature of the medical workforce required to sustain and improve medical care over the next decade or more, with particular regard to technological changes and the shift of some aspects of chronic care into a community setting. Given the lessons of MTAS, as a profession we must ensure we are at the centre of these sometimes uncomfortable discussions. In other words, our future and that of the quality of patient care depend on meaningful clinical engagement and real medical leadership – quite a challenge.

PROFESSOR IAN GILMOUR
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Guest Editor

THE FIVE PRINCIPLES OF THE DARZI NHS RECONFIGURATION PROPOSALS

Opportunity for NHS Reintegration or Preparation for Privatisation?

Lord Ara Darzi's Framework for Action, reconfiguring London's health services is, built around five principles. With none of these could one find any exception – in many ways they not only reiterate some of the fundamental principles of the NHS but also outline an evolutionary pathway for its development which many would find acceptable and some desirable.

The Framework itself sets out a vision for radical redeployment of our health care resources and establishment aimed to upgrade the quality of health care provision in an era of great change in the nature of the demands made upon it and of extraordinary advances in the means of provision. It is a potential restructuring of the NHS which could steer it away from its present path to privatisation and help return it to its original purpose of creating an excellent and equitable health care system which is also an expression of social solidarity.

It can also be argued that the effect – perhaps even the hidden purpose - of the Darzi proposals is to 'package' up the NHS, much along the lines of the US Health Maintenance Organisations, so that it can more conveniently be marketed for private sector purchase, a privatisation no longer 'piecemeal', but 'wholesale'.

We must be ever vigilant to protect the NHS from such destructive exploitation. To ensure this, any NHS reconfiguration must be constructed and implemented *within the NHS and by NHS agencies.* It must clearly be designed solely in the interests of improving the people's health. It must carry iron-clad guarantees of protection against commercial annexation. As 'Darzi's 6th principle', this would reassure the nation.

With such safeguards in place, it would be a mistake to allow theoretical fears to inhibit objective consideration of an NHS reconfiguration which could create radically better conditions for the provision of modern health care and set the NHS firmly back on its unique and successful social track.

It is in the light of these questions about the intentions which underlie the Darzi proposals that the five underlying principles of the Framework for Action have been examined and form the basis of this contribution.

1. Services focused on individual needs and choices

The ultimate unit of clinical activity is the individual citizen and respect for that individual is at the heart of the teaching and training of health care personnel at all levels. This recognition is closely linked with the principle of equity which ensures that access to the best care that can be offered is determined by clinical need and not by ability to purchase. It precludes the element of financial transaction from the therapeutic relationship and assigns priority of access to those judged to be in greatest clinical need. Choice will be exercised at all stages, from the technical selection of alternative health care strategies to the agencies, locations and providers of individual items of care. Effective choices require adequate information and its provision must be an integral part of the clinical encounter. This principle risks inevitable compromise when financial or commercial interests loom large in the choices made by the recipient or the provider of care

2. Localise where possible, centralise where necessary

Although this principle must be adapted to the type and complexity of care provided – essentially that the more highly skilled and specialised the treatment the more centrally provided it would need to be – it applies also to the governance and organisation of a reconfigured service. The creation at community level of comprehensive new Health Centres or Polyclinics which bring together the frequently needed services and facilities also provides important new opportunities for local citizen involvement in the development and running of the Centres. Here is an ideal opportunity

for professionals and appropriately prepared members of the public to work together toward the common purpose of optimising local health care provision, meeting special local needs, creating new local initiatives. Inevitably the composition and constitution of bodies responsible for setting strategies and making operational decisions would become more specialised and more centralised in respect both of technical expertise and resource allocation as one moves from the local, through the regional to the national, where priorities would be observed appropriate to that level.

3. Truly integrated care and partnership working, maximising the contribution of the entire workforce

This principle acknowledges the evident fact that the best patient care requires the harmonious and integrated activities of the community, the hospital, the social agencies and public health. The existence within the care providers of a transactional divide – the purchaser/provider split – imposed in an effort to create a market-like, contestational separation of these essentially collaborating elements operates in direct conflict with this important principle. With the bean-counting accountancy of items of service and the health-economist heaven of running so-called Payment by Results, vast and unproductive volumes of limited financial resources are consumed. The damaging purchaser-provider, generalist-specialist, hospital-community split must be abolished before this and all of the other principles can be realised and the full potential of the unique collaborative powers of the NHS can be mobilised.

4. Prevention is better than cure

The practice of prevention operates at many levels in the optimising of the health of the individual. Primary prevention, largely the province of public health, requires not only the exercise of long recognised disciplines with food and water hygiene but also their liaison with health care providers in the immediate detection of local community, industrial or employment risks to health and increasingly a community-based role in the prevention of non-communicable disease. The Public Health practitioner may at last find a proper constituency in the more fully integrated operation of the Polyclinic and Local Authority.

Prompt, facilitated movement of 'at-risk' patients with early signals of damage to appropriate specialised levels of care is the essence of effective secondary and tertiary prevention. It demands the provision of investigative skills and tools at primary care level and unencumbered pathways to remedial care as necessary. The unencumbered use of such preventive facilities to move swiftly between different sectors of the NHS represents another strong reason for the abolition of such barriers as the purchaser-provider split which has introduced new obstructions to the free movement of patients in the NHS since its introduction in 1990.

5. A focus on health inequalities and diversity

The Framework directs this principle to the dramatic variation in the type and degree of need across the varied socio-economic, cultural and ethnic populations of London, part of which has become notorious as the so-called post code lottery. There can be little dispute with the requirement to meet special needs with special facilities, a recognition that has been backed with all too little implementation over the years. Involvement of local populations in the planning and provision of health protection and care are of crucial importance.

One can see how tensions can arise between the need to delegate NHS decision making as close to community and neighbourhood level as possible but at the same time to ensure that everyone has equal access to the same items of care. This can in part be met by ensuring that there are centrally formulated and widely known national health goals but that to some extent the means of achieving them will be settled locally.

Falling outside the Darzi proposals for London but nevertheless of importance in respect of this Principle is the question of accessibility for people living outside large conurbations, especially those in rural and isolated communities. For such conditions, ingenuity, imagination and flexibility of organisation will be essential in providing a sound and reliable service. Mobility will be essential for both the providers and the recipients of care and transport facilities and physical access pathways will need special consideration.

Some Closing Thoughts

The Reconfiguration proposals are for London but presumably the 5 Principles are universal. The 6th certainly is.. It is clearly acknowledged in the Report and referred to above, that the Framework proposals are for reorganisation in London. Special consideration will need to be given to rural and isolated communities and even to cities other than London, unique in its size

and variety. It is proposed, wisely I believe, first to set up pilot areas within London and it is to be hoped that they will be closely and comprehensively observed, audited and reported upon. This would be a bureaucracy to be welcomed.

It is also to be hoped that those involved in the early pilot studies will be suitably prepared and motivated to take part in what will prove to be a pioneering new development, not only in the NHS but worldwide. There are unquestionably many people now working within the NHS who would wish to take part and make these early experiments a success. Conditions should be created to enable any health workers so motivated to volunteer for consideration for employment in the test site. Persons involved in setting them up should be meeting and discussing in detail the operation of this novel enterprise. Perhaps they already are..

Any such reorganisation will inevitably disturb the beliefs and practices of persons currently employed in the health services and predictably there will be much criticism and some opposition. It is to be hoped that attention will be paid to all well intentioned criticism and that any lessons learned or useful modifications proposed will be given consideration and incorporated into the subsequent waves of implementation. Special care must be taken to ensure that any loss of posts occasioned by reorganisation is anticipated and dealt with promptly and sympathetically by providing attractive opportunities for re-employment. At all times, the reactions of those providing reconfigured services and, at least equally importantly, the members of the public receiving them, must be sought, respected, and where appropriate and possible, acted upon. To the greatest possible extent these initial trials should be treated as a privileged practical exercise in democracy.

Finally, no direct reference is made to methods of funding the reconfigured service. It is assumed, one supposes, that the present methods of commissioning services from some primary care based body, presently in England, the Primary Care Trusts, will continue and this give tacit acknowledgment to the continued operation of the purchaser provider split. It would make very good sense to press for reconfiguration not only of NHS personnel and their relationships but also of the resourcing of the new NHS structure. It would surely give much greater flexibility and opportunity for redeployment if funding in the pilot areas was provided on the basis of an estimated block grant to cover the predicted costs of the new operation, to be administered perhaps through a special neighbourhood health council anchored onto a new Office of the NHS of the Local Authority and composed of both apponted and elected representatives charged with making the new service work.

The potential advantages of the London Framework should be put to the public with open and broad discussion of the likely changes and what they would be likely to mean to the citizens of London. Health care providers themselves will be persuaded by evidence of real improvement in service to their patients. Some early pilot sites, with Comprehensive Health Centres employing persons voluntarily wishing to take part in pilot trials of the new system might be the right way to start.

Whose NHS will it be?

Any proposal for major reorganisation of the National Health Service will inevitably excite a very mixed response both from the public and from health care providers. No one doubts that, with the massive changes in the medical needs of the population and in the enormously increased potential for effective therapeutic interventions, the means of provision of care must change as well to make the best of what can be done. It is essential that a medical service like the NHS has built into it the facilities for change and, calling as it does on the very best of the skills and human resources of British medicine and evoking as it does the sobering intensity of support, enthusiasm and confidence of the British public, it should be ideally placed to update its activities and structures and indeed to pioneer new approaches to the treatment and prevention of disease.

No Private Sector Buyout?

This public confidence can only be maintained if it is clear that there are no ‘hidden agendas’ involved in the changes being proposed. Explicitly, the public – and many health care providers - are disturbed by the growing involvement of commercial interests in patient care. There is real concern that ownership, direction, operation and development of all NHS primary care and specialist facilities should be firmly entrenched within the NHS and ultimately in public control. Explicitly, neither health care providers nor the public want to follow the US pattern of primary care and specialist services being provided on a market basis as profit-making enterprises.

HARRY KEEN

A member recently received this notice/invitation
which he thought a chilling insight into how far things have gone.

HealthInvestor Commisioning event

24th October 2007 – Central London

THE FUTURE OF PRIMARY CARE COMMISSIONING

Towards a New Framework for Independent Sector Providers

In the past provision defined the NHS, now commissioning will. The independent sector could have a pivotal role in commissioning future primary care services. A major programme of service reconfiguration has begun, driven by quality, access and financial issues at a national and local level. The political will exists to promote greater diversity amongst healthcare providers and the benefits are clear. It is anticipated that reducing restrictions on market entry would alleviate difficulties in under-resourced regions, increase the quality of failing practices, and provide patients with a greater choice of primary care provider.

All NHS commissioners must now undergo the "fit for purpose" exercise and engage fully with the contestability process regarding provider services.

Commissioning was the weak link in the internal market in the 1990's. Independent providers must raise their game if they are to negotiate on equal terms in a market characterised by business orientated financial regimes for public providers.

This event offers a unique opportunity to rethink what commissioning is about and who it is meant to benefit. Only then can commissioners begin to work effectively with a diverse range of providers to achieve improved health objectives for and with local people.

Contributors include

* Mike Sobanja, Chief Officer, NHS Alliance
* Richard Lewis, Senior Fellow, The Kings Fund
* Dr. Peter Greengross, Director of Strategic Consulting, Humana Europe
* Dr Mark Hunt, Managing Director, Primary Care Services, Care UK
* Richard Smith, Chief Executive, United Health Europe
* Mark Johnson, Managing Director, The Projects Partnership
* David White, Director, TNS Healthcare Acorn
* Ray Lowry, Senior Lecturer, Newcastle University
* Ged Taylor, NHS Networks Associate and Lead,

Commissioning with the Independent Sector Network

* David Hillier, Chief Executive, Capio Healthcare UK
* David Porter, Managing Partner, Apposite Capital

It is essential to gain greater clarification regarding the commissioning and providing role. Don't miss your chance to find ut more about open tendering as a means of ensuring innovation, quality and value and the opportunities which exist in offering real choice to people who use health services.

To book online please click here

Alternatively email carolyn.spring@healthinvestor.co.uk or call our events team on Tel 0207 451 7064.

Carolyn Spring, Event Producer, HealthInvestor

‘CARE CLOSER TO HOME’:
do intermediate services mean the end of quality care?

Care closer to Home’. ‘Convenient Quality Care for patients’. How cosy and pleasant these sound! No need to go miles away to the ‘monolithic’ (whatever does this mean?) hospital to wait ages to see the remote, arrogant consultant. If, that is, he can fit you in between the golf course and the Golden Nugget.. Now you can just pop round to your friendly, convenient community clinic and a ‘skilled health professional’ will know just what to do. And because those with less serious conditions are not going to the hospital, the hospital staff and facilities can be ‘freed up’ to concentrate on those who are really ill.

This is the spin. But what is the reality?

One must be charitable and assume that there is at least some desire for more convenient services, but there is also a wider agenda here. Terminology causes part of the confusion, and ‘Closer to home’ is pure Newspeak. The words mean what you want them to mean. For more than 11 years I and my GP assistant have done a weekly dermatology clinic in Ellesmere Port Community Hospital for the convenience of local residents, who often find it hard to reach the DGH in Chester. Is this ‘closer to home’ or ‘more convenient’? Apparently not. But if, instead of working with me, the same GP Clinical Assistant does a clinic on her own, in the same room but on a different day, it suddenly becomes ‘closer’ and ‘more convenient.’ This seems to be because she is then working for the PCT and not for the hospital. Indeed the original venue suggested for these dermatology community clinics was a room in the Countess of Chester Hospital, about 20 yards from our usual clinic rooms, and even this was actually billed as being ‘closer to home’!

‘Intermediate’ or ‘community’ services seem to take two main forms.

GPs with a Special Interest (GPSIs) may be employed directly by the PCT. Many have previously been Clinical Assistants and should, although many are not, still be working with a consultant at least once a month. Our new Chester GPSIs, still my Clinical Assistants on alternate weeks, are experienced and very good. In many other places this is not the case. Quality is a real concern and some serious problems have arisen. It is thought that over 2/3 of dermatology GPSIs will not meet the new GPSI accreditation criteria which have very recently become mandatory. Typically GPSIs are paid £250 or more per session, significantly more than a consultant session, and see fewer patients, so even the DoH admits that the real cost is higher than for a consultant clinic. Why, then, are PCTs forcing these schemes upon us all? The answer is, of course, money. PCT budgets, to be precise. Under Payment by Results, every new patient seen in a hospital clinic attracts ‘tariff’ payment from the PCT. For Dermatology this is currently £115, or £59 for a review patient. For a PCT with a big deficit there are clear savings to be made by paying a sessional GPSI and thus avoiding tariff. Even more money can be saved if a ‘triage’ or ‘referral management’ service can delay the referral or prevent it altogether.

Even more alarming are the other varieties of intermediate services, Clinical Assessment and Treatment Centres (CATS or ICATS). These are commissioned directly by PCTs or by GP groups as part of Practice-Based Commissioning. Hospital units can bid for the work (for which, even if successful, they will be paid well under tariff) but usually they are run by private companies. There may be no public consultation, or it may just be ignored. In parts of the North-West, Netcare has been appointed to run CATS in various specialties in spite of widespread opposition at packed public meetings. A survey by the Lancashire Evening Post showed that 71% of over 2000 readers thought there should be no CATS at all, while 95% thought Netcare should not run it. The Netcare CATS is to start in the autumn. These private-sector organisations may just be staffed by GPSIs or nurses but consultants may sometimes be recruited too, either from the UK or overseas. Doctors may be on short-term contracts with no long-term commitment to the service.

The appointment of these private-sector companies raises concerns of financial conflicts of interest. In south Liverpool, tenders were sought in April by a GP consortium to run a dermatology ICATS. The private companies Assura and Ourcare were appointed and the local dermatologists initially rejected on the astonishing grounds that they would be less able than the private firms to educate GPs in Dermatology. After publicity by KONP the dermatologists have been allowed to do some of the work as an additional ‘willing provider’ but concerns remain, particularly about allocation of patients to each group. One of the commissioning practices works in Assura’s premises (Assura’s website shows Mrs Hewitt attending the opening) while many GPs in the group, including the chairman, have shares in Ourcare. In surgical specialties running a CATS where the same company runs an ISTC to which it can direct patients, this is a particular worry.

How are patients allocated to ‘intermediate’ clinics? This varies. In some places the GP can choose either to refer to the GPSI or to the hospital, often with a protocol to advise on which conditions are suitable for the GPSI service. In Chester, referral letters addressed to the community

dermatology service are triaged by the GPSIs and some are sent straight on to the hospital clinic as are direct referrals coming straight from GPs. Often, however, all GP referrals in a specialty must be sent to a central point to be triaged, often by a nurse or even a clerical person who will then decide where they should go. The intermediate services are often said to be 'pre-choice'. The patient may have no choice about attending the intermediate clinic and will be unable to choose to go straight to see a consultant. Only if the intermediate clinic cannot deal with the problem will he be able to 'choose' a consultant clinic to attend. Even the official DoH document states that choice is not mandatory but PCTs should try to 'work towards it'. In Liverpool the proposed dermatology ICATS will take all referrals except malignant melanomas and squamous cell carcinomas. All other conditions, even erythroderma, will go to the ICATS. Quite apart from the lack of choice, this may cause unacceptable delays for seriously ill people.

How do intermediate services affect the hospital service? Even if there is no intermediate service locally, the threat of one is real and produces enormous uncertainty. Nobody can tell when, or whether, the PCT or GP commissioning groups will ask for tenders for a CATS. Even a small community service represents significant financial loss to the hospital when out-patient numbers are cut, while a major CATS development may be devastating. If large numbers of patients are retained in the CATS, this is likely to lead to staff losses and may well make the hospital unit non-viable. 50% of dermatologists in a recent survey said their PCT was setting up a dermatology CATS. 1/3 said this had led to instability, and redundancy was being discussed in 1/4 of Trusts. At least one, Newham, has declared that their dermatology and rheumatology services must close. In such cases, a GPSI, often working for a private company, may be the only opinion available. The DoH guidance on PBC does not appear even to mention possible consequences for secondary care.

What of the effects on the wider profession? A tragic result of such schemes is that they create antagonism and suspicion between consultants and GPs. In the past, any GP expressing an interest in furthering his dermatological knowledge would have been welcomed and encouraged. If he wanted to do a dermatology diploma he would be invited to attend clinics and perhaps we would organise teaching sessions and support. No longer so! Now we would not see an enthusiastic colleague, but a future GPSI whose activities would undermine our service or, even worse, an employee of Assura or Netcare. Out of 90 GPs taking a recent dermatology diploma, 86 planned to be GPSIs. Only 4 just wanted to improve their skills in general practice, the actual intention of this diploma. Many GPs considering GPSI work or practice-based commissioning do not really understand the implications of their decisions on the hospital service as they are not familiar with the finer details of funding. Others, sadly, do not seem to care. There is no strategic planning.

Training is a very serious issue which is all too often ignored. Even the 'intermediate' services themselves may be non-sustainable. Doctors working as GPSIs for the PCT or for private companies have usually, though not always, spent a significant time working with a consultant as a Clinical Assistant or at least attended regular clinics for a few months. They must all do so when GPSI accreditation becomes mandatory. But if their local consultant unit has closed, how will this be done? What range of patients will medical students, GP registrars or specialist trainees see if most conditions are diverted to another 'provider' unsuitable or unwilling to teach? And what do patients think? Are the worries of hospital doctors just 'provider interests' as the Government says? It seems not. In dermatology the umbrella group Skin Care Campaign represents the interests of patients and not of doctors, except where these coincide. The SCC issued briefing papers in 2006 and again this year, outlining its increasing alarm about 'the implications for patient safety, care and choice, and for the future of specialist dermatology services, inherent in so wholesale and indiscriminate a service change'. Particular concerns of the SCC include triage by non-consultants, lack of continuity of care and lengthening of the patient journey. Although the '18 week pathway' supposedly applies to 'community' services, this is monitored much less stringently than in the hospital service. In some parts of Merseyside, referral letters addressed to consultant dermatologists are intercepted by the PCT and triaged by nurses. Patients not triaged to the hospital clinic will then have to wait up to a year to see a GPSI before possibly being referred on. If patients are referred on from community clinics a new GP referral is often required to avoid target breaches. There are real problems of continuity too, made worse by the fact that community doctors are unlikely to have access to previous hospital notes and by the financial arrangements which often overtly discourage any review appointments at all.

Community services may be more convenient for some, but there is a big price to pay.

What is the agenda? Convenience, possibly, but this must also be in part the continuing attempt to downsize DGHs, to involve the private sector and to disempower consultants. Dermatology is one of the first specialties targeted for wholesale removal to 'the community' but will not be the last. Rheumatology is likely to be next and others will doubtless follow. Patients with the most unusual or severe problems, or with multiple pathology, have the most to lose if they are seen by non-specialists or are admitted to hospitals which have lost their consultant service.

So, 'convenient quality care'?

We should not be optimistic.

ANDREA FRANKS
Chester

The Database of Uncertainties about the Effects of Treatments (www.duets.nhs.uk)

There are many important uncertainties about the effects of treatments. Some of these are inevitable: for example, it is very rarely possible to be absolutely certain what the effects of a particular treatment will be in a particular patient. Sometimes uncertainties about the likely effects of treatments can be reduced by systematically reviewing relevant research. Often, however, either no relevant up-to-date systematic reviews exist, or such reviews make clear that the existing evidence shows that there is simply not enough reliable evidence available.

It is this third category of uncertainties that need to be identified and considered for further research to help ensure that the treatments we use are likely to do more good than harm. Acquiescing in this category of uncertainty can mean acquiescing in lethal treatments – sometimes over decades – as recently shown to have been the case with systemic steroids given to people with acute traumatic brain injury (CRASH Trial Collaborators. Lancet 2004;364:1321-8.)

The research priorities of people working in academia and industry cannot be assumed to address questions about the effects of treatments that are important to patients, carers and clinicians. For example, when patients, rheumatologists, physiotherapists and general practitioners were asked to identify their priorities for research on the management of osteoarthritis of the knee, there was little enthusiasm for the studies of drugs that dominate research on treatments for this condition. Patients and clinicians said they wanted more rigorous evaluation of the effects of physiotherapy and surgery, and better assessment of the educational and coping strategies that might help patients to manage this chronic, disabling and often painful condition (Tallon et al. Lancet 2000; 355: 2037-40).

The Database of Uncertainties about the Effects of Treatments (DUETs) was conceptualised during the summer of 2004, after a decision had been taken to establish the James Lind Alliance to encourage patients and clinicians to work together to prioritise unanswered questions about the effects of treatments (see www.lindalliance.org). The first such patient-clinician working partnership was formed by Asthma UK and the British Thoracic Association. Uncertainties about the effects of treatments for asthma were first assembled in DUETs, and then considered at a formal research prioritization meeting earlier this year (report available at www.lindalliance.org). It emerged that reliable evidence addressing uncertainties about the long term effects of chronic use of steroids, bronchodilators and other drugs for asthma was outstandingly the most salient 'felt information need' of patients, and parents of patients. This and other identified priorities identified have been notified to the National Institute for Health Research and the Medical Research Council.

DUETs modules of uncertainties about the effects of treatments in other fields are being developed and maintained under the aegis of the Specialist Libraries of the National Library for Health (www.library.nhs.uk/specialistlibraries), and will inform research prioritization in future. The James Lind Initiative, which receives funding support from the Medical Research Council and the English Department of Health, provides Secretariats based at the Summertown Pavilion in Oxford for both the James Lind Alliance and DUETs.

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The Darzi Plan for London

There have been many attempts to understand London's health problems and how the NHS can shape up to address them. This latest plan is the first under an all-London NHS bureaucracy and seems to have government backing. What does it say and what are the chances of success?

The first part of the report answers the question 'Why Change?'. It sets out London's health needs and problems recognising the diversity and age of the population, its distribution of hospitals, poor state of general practice premises and the resultant inequalities in health experienced by Londoners.

None of these 'findings' are new. Many organisations,

including the Medical Practitioners' Union, were shouting about them 20 years and more ago. The first surprise in this report is therefore the use of rhetoric that would have graced a left wing agitational leaflet of the 1970's. There is now recognition that the causes of ill health lie outside the remit of the NHS and that working with local authorities and other organisations will be required. Little is said about the effect of poverty and poor housing.

Then of course there is the driver of living within the NHS budget. The plan aims to release £1.4bn by massive re-structuring of hospitals and primary care

The plan rests on five principles:

1 Services focused on individual needs and choices
2 Localise where possible, centralise where necessary
3 Truly integrated care and partnership working, maximising the contribution of the entire workforce
4 Prevention is better than cure
5 A focus on health inequalities and diversity

The key proposals are:

- More healthcare should be provided at home.
- New facilities – polyclinics – should be developed that can offer a far greater range of services. (eg extended urgent care, healthy living services, community mental health services and social care) than can be offered by GP practices, whilst being more accessible and less medicalised than hospitals.
- Local hospitals should provide the majority of inpatient care.
- Most high-throughput surgery should be provided in elective centres.
- Some hospitals should be designated as major acute sites, handling the most complex treatments.
- Existing specialist hospitals should be valued and other hospitals should be encouraged to specialise.
- Academic Health Science Centres should be developed in London to be centres of clinical and research excellence.

The report says: "The majority of urgent care centres will be based in polyclinics. Polyclinics will be able to provide the consulting rooms and diagnostics that will be crucial to shifting much planned care into community settings. And they will provide the integrated, one-stop-shop care that we want for people with long-term conditions".

"Elective centres will focus on particular types of high-throughput surgical procedures such as knee replacements, arthroscopies and cataract operations. This work will be separated out from emergency surgery to achieve better clinical outcomes and productivity".

In making change and improvement happen the main drivers are:

- commissioning
- partnerships to improve health
- public support
- clinical leadership
- training and the workforce
- patient choice and information
- funding flows
- better use of our estates.

Clearly such a massive restructuring is being proposed so London can live within its NHS budget. Yet paradoxically the model proposed may be more expensive. There are the new buildings to pay for - hugely expensive via PFI; complex workforce issues - training, change in contracts, new work practices, and more services at home - the evidence with community matrons is that their development if often at the expense of a reduction in basic district nursing services. The government no doubt will offer more NHS work to private companies at a premium.

If the model is more expensive and the budget has to be reduced either the service to patients becomes massively more efficient or there will be cuts in service. No doubt Prof Darzi hopes for the former but history is not on his side. The last attempt to 'reform' primary care/general practice in London - The Tomlinson Report - failed to have a lasting effect and there are political barriers to closing, or even restructuring, local hospitals. The power of doctors and their organisations to subvert and prevent change is legendary and has been a force for good and bad.

The reality of general practice in London reflects the low number of doctors overall in the UK. The failure to organise GP income in the New Contract to truly reflect working in deprived areas and attract young Gps to work in difficult areas means that money has again flowed to affluent areas. The apparent overpayment to Gps means that there is now little money to exploit the 'enhanced services' payable under the new contract which could have paid Gps for working in deprived areas and for working with patients who do not speak English, for example.

In other words the rhetoric of addressing inequalities that was an aim of the New Contract failed and I see little in Prof Darzi's report that will address inequalities either. Why? Because addressing inequalities costs money and London is already assessed as 'overspending'. That's the real reason for this whole Report.

RON SINGER
GP Edmonton, North London
and president, Medical Practitioners' Union

The June Newsletter carried a series of reports on the possible direction of health policy following political changes throughout the UK.

This update shows some encouraging early developments

NHS WALES & SCOTLAND: MONEY - CHANGERS DISMISSED FROM THE TEMPLE

Here are some quotes from *One Wales*, the policy statement agreed by Wales Labour and Plaid Cymru in the new government of the Wales Assembly:

"We firmly reject the privatisation of NHS services or the organisation of such services on market models. We will guarantee public ownership, public funding and public control… We are resolved to keeping the NHS publicly owned, funded and managed… We will move purposefully to end the internal market…We will eliminate the use of private sector hospitals by the NHS in Wales by 2011… We will rule out the use of Private Finance Initiative in the Welsh health service... We will end competitive tendering for NHS cleaning contracts… We will maintain free prescriptions… We will build on existing workforce plans to include all care staff, with a strong emphasis on work-based training to enable individuals to gain qualifications on the basis of their practical skills and to develop those skills further…"

And so on. If Rhodri Morgan had gone into the recent Wales Assembly elections with this programme, and if Tony Blair had not invited himself to come and blight its campaign in the eyes of Welsh voters, Labour might still have a majority. But then we wouldn't have entered this exciting period of new opportunity, bringing together the real socialists to be found in both parties, Labour and Plaid. This has thrown some of their more fossilised members and more lickspittle MPs into confusion.

Something similar is happening in Scotland, where the SNP's new health minister Nicola Sturgeon told the NHS Confederation annual conference:

"Before the election, a poll showed that voters' top concern was of creeping privatisation of schools and hospitals. The Scottish public expects public money to support public services rather than the private sector. They believe that public services should be delivered by public servants…We reject the very idea that markets in healthcare are the route to improvement. We believe, instead, that it comes through the collective energy and ideas of committed staff, working with patients, and the communities they serve."

The Labour-Liberal Democrat government in Scotland had already ended the purchaser-provider split, the foundation on which all plans for NHS privatisation rest, but still loudly proclaiming loyalty to Blair and all his works. So, as in Wales, Labour's traditional voters were determined to teach its representatives a lesson. Proportional representation helped them to do so without handing power to their oldest enemy, the Conservative Party. One party rule is finished in Celtic Britain, and good riddance to it.

Meanwhile, the NHS in England is falling apart. The promise of greater efficiency has not been delivered. The profitable procedures contracted out to private companies have not been profitable enough to satisfy investors, and even after trebling NHS spending, there's not enough left to pay for the unprofitable emergency and chronic care which the NHS will never be able to evade. A new study by the NHS Commercial Directorate shows that private sector hopes are receding. For the NHS to attract the big multinational corporations Blair wanted, between 450,000 and 500,000 procedures needed to be contracted out from the NHS each year. Even if contracts still under negotiation are included, this figure now seems unlikely to reach even 300,000. This is because most doctors and most patients want to

use the local NHS hospitals they know and which operate as public services, not what many see as slick new operators working for profit.

New Labour's electorally disastrous policy of privatising public services won't go away by itself. Desperately trying to hang on to private investors with growing doubts about quick profit from this field, government is now subsidising bidders. A disappointed bidder for a Private Finance Initiative contract for work on two hospitals for the North Bristol Trust complained the company would lose millions already spent in preparing its bid. Interviewed by the journal *Health Matters*, a spokesperson for the Trust said compensation around £6m was being considered to offset this loss.

Interest in PFI has been declining steadily over the past three years for similar reasons. To maintain this originally Conservative policy, government must steadily shift the financial risks of competitive investment away from investors back to the taxpayer. This will continue until the policy itself is abandoned.

Wales and Scotland are showing that marketisation of health care and education was not just unprincipled, for leaders who claimed to be socialists, but grossly inefficient, because it assumes that the only reason anyone does anything is to make more money for themselves. This is insulting and demoralising to health workers and teachers. At its worst, it becomes a self-fulfilling prophecy.

Above all, it ignores the huge, still largely unused, contributions to health and education which can be made by patients and students themselves, once they feel that these services belong to us all, rather than to remote officials from some other planet. We know this is true, because we see it every day, in the NHS and in schools and universities still struggling to uphold the spirit of public service. In this respect, Wales and Scotland, with their loosened-up parties and politics, promise to become liberated areas. When will England follow?

DR JULIAN TUDOR HART
Swansea
(This article first appeared in the Morning Star www.morningstaronline.co.uk)

RECENT DEVELOPMENTS IN ACCIDENT AND EMERGENCY

The current hot topic in A&E is reconfiguration of emergency care, or put simply, whether A&E departments in some smaller general hospitals should be downgraded while larger hospitals develop specialist centres of emergency care. Amongst patients the "winners" of such a policy would potentially include those with major trauma, heart attacks or strokes who would benefit from rapid access to specialist care. The latter two groups are being targeted under the "Hearts and Minds" policy. The potential "losers" include patients with serious life-threatening conditions that require urgent but non-specialist care, whose travelling times to hospital may be increased. Before we consider this trade-off it is worth examining the evidence to see whether these assumptions are supported.

Emergency angioplasty for a heart attack (which can only be provided at a specialist centre) is more effective than thrombolysis (which can be provided at any hospital). It is associated with a 2% absolute reduction in mortality, 4% reduction in subsequent non-fatal heart attacks and a 1% reduction in subsequent stroke. These are not huge differences but are worthwhile for the individual patient. However, being derived from randomised trials, they probably represent the best-case scenario and will only be reproduced in practice if hospitals can organise services so that angioplasty is rapidly available 24 hours a day. The National Infarct Angioplasty Pilot Project (NIAPP) is being undertaken to determine whether this is feasible in the NHS and whether such a service would be cost-effective. Initial findings suggest that emergency angioplasty can be widely provided without unacceptable delays, but full results will not be available until 2008.

Stroke units are associated with better outcomes than general medical care, but it is not clear whether emergency stroke care requires specialist intervention. The main emergency treatment for stroke is thrombolysis, which should ideally be given within three hours of symptom onset. General or emergency physicians can

administer emergency stroke thrombolysis provided they have 24 hour access to CT scanning and either the skills to interpret the scan, or a radiologist to do the job for them.

Although specialist care would intuitively seem to be crucial for major injuries, there is surprisingly little clear evidence available, mainly due to the difficulties of undertaking robust evaluation. Most evidence of improved outcomes with high volume, specialist trauma care comes from the United States, where the contrast between rural community hospitals and major trauma centres is profound. An evaluation of regionalisation of an NHS trauma service in the 1990's showed no effect, mainly because of the difficulties of achieving a genuinely centralised service.

On the other side of the argument, it would also seem intuitively obvious that increasing the distance that patients have to travel with a life-threatening emergency will decrease their chances of survival. Until recently, however, there has been little evidence to support this hypothesis, leading some to doubt whether it is an important issue in practice. A study from Sheffield University of over 10,000 patients transported to hospital with a life-threatening emergency has now been published showing that the patients' probability of death increased by about 1% for every 10km increase in distance they had to travel to the hospital. This effect was more pronounced in patients with respiratory emergencies and was not altered by adjustment for confounding by age or illness severity. It seems that increasing the distance that patients with life-threatening emergencies have to travel may increase their chances of dying. As with the effect of angioplasty upon heart attacks, the magnitude of the effect is not huge.

The Sheffield study was a secondary analysis of data collected between 1997 and 2001, so an acknowledged limitation is that developments in paramedic practice may have attenuated the effect of journey distance upon mortality. However, paramedic practice was well established in the study cohort, as evidenced by the high level of patient monitoring reported and used to adjust for illness severity. It is also difficult to identify any changes to paramedic practice since 2001 that would have markedly influenced mortality. Furthermore, most evidence for paramedic effect upon mortality relates to cardiac arrest cases, and these were excluded from the analysis.

Superficially we would therefore seem to be faced with a trade-off between, on one hand, the current system in which patients with respiratory emergencies benefit from rapid access to general emergency care, while those with heart attacks and possibly strokes or major trauma suffer from lack of access to specialist care, and on the other hand, an alternative system benefiting those requiring specialist care but increasing the risks for those needing general care. In practice, however, this may be a false dichotomy. If we decide that the benefits justify the additional resources we could establish centralised specialist care without sacrificing local general care. Of course, this may require us to either remove resources from elsewhere in the health service or find even more healthcare funding. It would also require systems to accurately direct patients to the most appropriate location.

Ultimately, however, it may be worth putting some of these "life or death" issues in perspective. Emergency angioplasty is specifically aimed at patients with a certain type of heart attack (ST-elevation myocardial infarction) and these cases make up only about 3% of A&E attendances with chest pain. A recent North American study showed that only 1% of patients with a stroke were given thrombolysis. Major trauma cases make up only 0.1% of A&E attendances. Meanwhile, the Sheffield study focussed upon selected high priority 999 calls. The debate risks focussing upon a minority of high profile conditions for which the potential impact of changes in service delivery may well be marginal.

While the debate rages, the needs of the overwhelming majority of emergency department attendances and emergency admissions are in danger of being ignored. Increasing numbers of patients are attending acute hospitals as emergencies and being admitted, despite (and maybe even because of) recent developments in primary care. Most of these patients do not have immediately life-threatening problems or need specialist care, but they do have complex health and social care needs. It remains very difficult to differentiate these patients when they call for help from those requiring urgent or specialist care, so wherever we direct the patients with life-threatening emergencies, large numbers of others will follow. Perhaps the idea of having a rather messy front door to the hospital, where doctors or nurses with a broad range of skills assess everyone, isn't such a bad idea after all.

STEVE GOODACRE
Sheffield

Defending the NHS in Merseyside and Cheshire

Alex Scott-Samuel
(a public health academic writing here in a personal capacity)

Last September I recorded and transcribed the following quotation from Ed Balls, now Secretary of State for Children, Schools and Families in England. He spoke on a Radio 4 programme entitled "What does Gordon really think?" which went out on 23 September 2006: *"There are areas which are called 'public services' precisely because there are limits to the way in which markets work. A market in health care doesn't work – whether you judge that on the basis of cost and efficiency or fairness and access – and that has never been a road which we have thought about going down and I don't think we ever will; and I think if there is any uncertainty about that we should just clear it up."* You can still revisit this recording at: www.bbc.co.uk/radio4/news/pip/fpg6t

At the time of writing, we are two months into Gordon Brown's government and there is no sign of movement in the direction implied by Mr Balls' statement. True, Brown is generating the impression of a man with some sympathy for the welfarist values which his predecessor did so much to destroy. But aside from a little spin here and there - such as stating that there will be no third phase of foundation trusts, when no such phase had ever been announced - nothing has been done to limit, or better still, eliminate the creeping, continuing privatisation of our clinical health services.

Merseyside is probably no different from other areas in this respect. Our small and courageous Keep Our NHS Public group is doing its valiant best to challenge the Goliath of government policy and its local exponents. Current campaigns include opposition to the introduction of a privately provided GP service in Maghull, to the threatened privatisation of dermatology services in South Liverpool, and to unethical manipulation of GP referrals to orthopaedic services in Cheshire.

In Maghull, 160 angry local people attended a public meeting following Sefton Primary Care Trust's attempts to award the provision of a GP service to an (officially unidentified) private company. The result was the formation of a vocal Keep Our NHS Public subgroup which now has speaking rights at PCT board meetings and which has forced the PCT to undertake public consultation on this issue.

In South Liverpool, a GP Practice Based Commissioning (PBC) consortium established by Liverpool PCT, attempted to exclude the regional NHS dermatology service at Broadgreen Hospital from its bidding process for new community based dermatology services. The so-called 6 month pilot community service, which would undermine the continuing provision of the current regional service, was advertised with no prior local consultation - and the NHS service was (inexplicably) deemed not to meet its provision criteria relating to GP education.

Furthermore, the commissioners attempted to award the contract to, among others, a private company one of whose shareholders is the PBC consortium's Chair! The PCT chief executive subsequently stated in a letter to Peter Kilfoyle MP that this GP, who acted as clinical adviser to the interview panel, 'provided impartial clinical advice, without bias' and that 'in view of the nature of PBC such potential conflicts of interest will frequently occur'.

Our action on another issue recently led to headline publicity in the Health Service Journal concerning Western Cheshire PCT telling GPs across its area to refer orthopaedic patients needing arthroscopies, hip and knee replacements directly to an under-used independent sector treatment centre. At present GPs in the area first have to refer orthopaedic patients to an orthopaedic triage service run by the PCT – entirely appropriately given the invasive and specialist nature of the interventions involved. 'The decision has been taken due to the scale of the

treatment centre contract, which is currently being under-utilised,' the PCT's letter states.

During my 35 years as a medical practitioner and my 30 years as a member of NHSCA I have never known the values of the NHS - not to mention its culture and morale - to be so directly challenged and undermined by government policy as has been the case in the latter years of the Blair government. As a member of the Labour Party I am horrified and disgusted by the destruction of the publicly provided welfare system I hold so dear. I find it hard to believe that Gordon Brown identifies with what has gone on: but has he the courage to change it?

Alex Scott-Samuel can be contacted at alexss@liverpool.ac.uk

PFI News

I thought you may like to be acquainted with a momentous decision taken at Leicester over the last few days.

The acting Medical Director of UHL (University of Leicester NHS Trust), Dr Anderson John, informed me this afternoon of the reasons why UHL had withdrawn from the Pathway Project (the PFI scheme) at a Board meeting on Thursday evening. The Pathway Project was a multi million pound investment in the three city hospitals which was amongst the most expensive PFI partnership outside London (I believe only Birmingham would have cost more).

UHL had been seeking "foundation status" in order to control its own budget and to shape hospital services around local needs and not national needs. In mid April this year it decided to delay seeking foundation status for the second time in 2 years to enable it to control its finances and to concentrate on the Pathway Project.

The Pathway Project was initially costed at more than £800M but was reassessed at £574M last year. In April this year most PFI schemes were cut by 25% to 40% with the exception of two Trusts —UHL which rose by 24% to £711M and that at Pinderfields Hospital (Mid Yorkshire Hospitals Trust) which rose by 29%. The former was Mrs Hewitt's constituency the latter, Ed Balls.

Seven years ago the Pathway scheme was sold to the Leicester public by saying that it was essential because redevelopment was necessary to sustain the hospital service.

The decision to scrap the PFI scheme was taken because Triskelion (the PFI commercial consortium partner) has stated delays had resulted in costs spiralling to £921M. This would have increased annual payments for PFI by £19M annually resulting in an increase over 30 years of £570M. The annual charge would have become £82M.

UHL will have reduced revenue as the SHA has capped the money that UHL can obtain from PbR (Payment by Results) and the local PCTs are not increasing their expenditure. A review of health services in Leicestershire and Rutland is being carried out by Tim Rideout, Chief Executive of Leicester City PCT.

It has been disclosed that £23.4M of taxpayers' money has already been spent on the project. In addition, Triskelion is to sue in making a massive claim of several million against UHL; the CBI has pointed out that Triskelion has spent a fortune on preparing its bid for the contract and on drawing up plans for buildings and alterations.

Mrs Hewitt commented that she was disappointed but believed the Trust had made the right decision. Another local MP, Mr Keith Vaz, believed the Pathway Project had been a catalogue of errors and believed that "heads should roll." He considered it a damning indictment of Trust management and that whoever was in charge of the project should resign.

Mr Vaz questioned the Health Minister Mr Ben Bradshaw yesterday in the House of Commons. The Minister admitted the decision was "shocking" and offered to meet MPs to discuss it.

Two other PFI schemes have been pulled recently -the £150M scheme at Colchester and the £200M scheme at Torquay.

UHL now intends to apply for "foundation status"

Personally I think this is a triumph for common sense and I hope more PFI schemes will be scrapped (and regret the application for Foundation status).

GEOFFREY LEWIS

THE AGM, CONFERENCE and DINNER

Saturday 6th October

All members should last month have received details and application forms for these events. If any have gone astray further copies can be obtained from NHSCA – contact information at the end of this Newsletter.

At the time of going to press it is still uncertain whether Professor Darzi will be able to attend to speak on that date but if he cannot, the Committee plans to arrange a special meeting for that purpose in view of the importance that his proposals have, firstly for London but eventually for most other areas.

We will be electing the Executive Committee for the following year and already have one or two vacancies, so will be looking for nominations or volunteers. Please submit names in advance if possible – it is not essential that the nominee is actually present on 6th October. We appreciate that today's contractual arrangements make it increasingly difficult for many people to get away from work and do not expect all members to attend all meetings which are not in any case very numerous. Two people from the same area sharing a committee place and alternating their attendance has proved a useful arrangement in the past. **We are particularly anxious to have a committee member from the West Midlands which is currently unrepresented.**

It is perhaps an appropriate moment to consider the future format of our AGM etc. Although it will probably be discussed at this year's event it is clearly important to get the views, on a number of aspects, of those who for whatever reason will not be present.

The day of the week was changed some years ago to Saturday in view of the difficulty many were having in taking time off mid week. It seems unlikely that we could alter this now.

The venue. Originally we tried to hold the meeting in different places and have been to Birmingham, Glasgow, Manchester, Liverpool, Buxton York, Durham, Bristol etc in the past. As the Association grew the view was expressed that for most people the two capitals of London and Edinburgh were the easiest to get to so we have in recent years alternated between the two. Is that still what most people want? To hold it in a different city does of course need a small group of local members who will help with on site arrangements like identifying venues.

The format This has been essentially unchanged for many years – formal AGM, Conference and Dinner. Is this still what the majority want and with what balance? For instance, we could have more of a working AGM with debates and decisions on policy and less emphasis on outside speakers.

We would very much appreciate your views on any or all of these topics.

Finally **Membership** I am pleased to report that we are now for the first time very close to 700 members and might be there by the time you read this. It may not seem a high proportion out of those eligible to join but it is certainly a bigger one than any political party can claim – and **we** are growing.

The more of us there are the greater our influence. Of the recruitment methods we use the most effective has always been personal contact and recommendation.

With all the controversy surrounding the NHS at this time it should not be difficult to assess which of your colleagues might share our view that health care should be a service, not a business, and so be worth a mailshot. All you need to do is let us know who they are, your name will not be mentioned unless you specifically ask us to do so.

PETER FISHER

Diabetes and Endocrinology in the Darzi plan

The Darzi plan is the most radical and dangerously non-evidence-based revolution in the delivery of healthcare in longterm conditions anywhere in the Western world, based, uniquely and arrogantly, on minimal and restricted access to consultants. Its relentless, obsessive and doctrinaire emphasis on primary care-delivered services at the expense of district general hospitals smacks of totalitarianism (Darzi is quoted as saying: "the days of the district general hospital seeking to provide all services to a high enough standard are over"). This is a government with a mission, an inexorable historical self-fulfilling trajectory that started with the consultant-delivered NHS Plan (2000), then moved to its radical reincarnation as a patient-centered and non-consultant delivered service ("Putting People at the Heart of the Public Services", 2004). The next step was a health service where hospitals and their reactionary consultants play only walk-on extra roles when cheaper alternatives couldn't be found ("Our Health, Our Care, Our Say", 2006), culminating in the glorious climax of the Darzi plan, where both the concept and politics of the DGH have been obliterated in a vicious combined ideological onslaught from the Department of Health and the Institute of Public Policy Research (The Future Hospital, 2006-2007) softened by Darzi's delicately-spun image as a real doctor of the people.

In this breathtaking historical sweep, diabetes has, of course, no place at all, barely worth even a mention in the grand statements above, other than a splendid example in the 2004 document of a 30 year old Type 1 diabetic patient planning a pregnancy using web-based advice without, apparently, the clinical input of any healthcare professionals – a sexy techno-approach guaranteed to improve the UK's dismal record of pregnancy outcomes in diabetes. In truth there has been no change in the policy on long-term conditions since my leading article for the Newsletter in 2005, except the removal of any residual hope that, harking back to fundholding, good hospital departments would attract increased attendances and funding through payment by results. Foolishly I hadn't anticipated "referral management systems" that prevent GPs referring long-term and expensive conditions into hospitals, nor increasingly pugnacious hospital-avoidance strategies devised by PCTs or the emotional wooing of patients back to their cosy general practice diabetes "specialist" nurses (known to most of us as practice nurses). In the last 6 months, I have been referred 19 cases to my diabetic outpatient clinics – about an 80% reduction over the past 4-5 years. It isn't believable that primary care has improved to a level where virtually no patients require hospital referral. The outcome will be a pandemic of end-stage renal disease over the next 5 years, which may, despite the government's best efforts, turn into embarrassing hard data. Conversely, and wholly predictably, my workload of worried well "endocrine" patients from out of my immediate catchment area, perhaps with a minor thyroid disorder previously easily manageable by correspondence, telephone or email, has rocketed, galvanized by the unlimited funding of the Choose and Book system. This is a perversion of the fundamental principles of the NHS.

Many Trusts are complicit. Those slugging it out to become the few super-A&E hospitals in the Darzi plan are dropping long-term conditions like a stone, while slicking up their acute portfolios to fulfill Darzi's prophecy. The number of consultant posts in diabetes and endocrinology was already plummeting at the end of last year (DUK/ABCD survey); if retirement positions are being replaced at all, then it is with posts in acute medicine, so that 4 hour wait targets and decreased length of stays can be achieved, resulting in the fewer acute beds desired or required by foundation/PFI hospitals. The last two consultant appointment committees I sat on had around 20 applicants, the majority highly appointable; only 4 years ago we had to readvertise our own third consultant post because of lack of applicants. Trainees will, after the fall-out of the current bulge, simply run with the market and opt not to train in diabetes and endocrinology. The specialty will cease to exist; research, except the most pragmatic, access- and patient-centered, and endorsed by the newly-centralised research bureaucracy of the DH, will stop. But diabetes itself will do anything but stop. As I pointed out in 2005, this brilliant experiment may well result in more end-stage diabetic complications, in contrast with most of our European neighbours, where the worst manifestations of diabetes look, finally, as if they are beginning to stabilize or decline. The UK, or at least England, at the top of yet another European league-table: horrible diabetic complications.

DAVID LEVY

News about KONP

As we go to press, the main news about KONP is that every effort is being made to influence the Brown government *before* it announces the main planks of its health policy. As well as writing to and seeking meetings with key ministers, members of the steering committee are not forgetting the climate of opinion in which announcements will be made – the media.

Like so many worthwhile campaigns, raising funds week after week is a constant theme. A new idea that was discussed at the August meeting of NHSCA's executive committee was for a booklet containing a glossary of terms used to describe the new NHS. This would be much shorter and more dictionary-like than Allyson Pollock's important and recent book on this subject.

It was further suggested that the glossary might be part of a booklet that contained a second edition of the very successful booklet on *Patchwork privatisation* that Alex Nunns wrote. This has been ordered by some unions by the thousand so, if done very well, it could again turn into a money-spinner.

If you have a pet subject on which you could write a paragraph (or two at the most), please send a note to Peter Draper – peter@draper1.plus.com - examples might be *Commissioning* or *The Darzi health plan for London.* At this stage don't draft – just send the title of the topic you would be interested in defining. Offers of help in editing would also be welcomed.

New government – same old spinning

Have you noticed the latest word-corruption being used to denigrate the NHS and its staff? We now keep hearing about the need to get away from *one-size-fits-all* services with the implication that the NHS – and its staff - are intrinsically rigid and bureaucratic.

The nice thing about this otherwise sadly typical and essentially snide attack is that it so obviously comes from characters who clearly don't know the first thing about clinical services. As if our 'mostly very good' services could be provided without constant adaptations to individual patients and to their varied and often multiple clinical problems.

Furthermore, the spinners haven't twigged that the corporate lust for profitable cherry picking is precisely about selecting 'straightforward, easy patients' for quick bucks. The profiteers select standard cases – and as usual – leave all clinical complexities to the NHS – or nothing.

Just who dreams up these hostile phrases – and scatters them liberally into 'New Labour' party briefings?

The answers may lie in the same direction as the people who coined the term 'creative destruction' to cover what were anticipated as the organisational chaos that would arise from their often daft and usually ill-prepared policies for the NHS. Indeed, some argue, with reason, that *NHS instability* was an essential environment for privatisation, (ugly word but accurate) - for 'corporatisation'.

PETER DRAPER

Health Politics: A spiral up or down?

The NHS was the idea of the Labour Party, driven through by Aneurin Bevan in the mood of reconstruction after the Second World War and in the teeth of opposition from many doctors, among others. In 1948 2.5% of the gross national product was devoted to this initiative. A guiding principle was clearly the philosophy of the Armed Forces medical services: get the worker in shape so he can get back on the job. It was also accepted that medical care of the pregnant, children, the elderly and the mentally ill was a social responsibility the State should shoulder on our behalf. It was expected health care expenditure would actually fall as folk got fitter!

But continual re-organisation and social change have altered perspectives dramatically. The rise in the proportion of elderly, the introduction of more effective therapy, and the demand for expensive new developments in medical care has created demands which are much more costly to meet. By the 1990's 5.5% GNP went to the NHS, with a further 1.1% spent on private care. Now 8% of GNP goes to the NHS, similar to budgets for health care in Western Europe, though a long way behind the 14% spent in the USA.

With more than a million staff the NHS is the third largest employer in the world, after the Chinese People's Liberation Army and Indian Railways. The basic structure survived until 1974 when the Area Health Authority was created only to be abandoned in 1982. The pace of re-organisation has quickened since then with a turmoil of new initiatives often grafted on to ideas of the past.

The Ministry of Health became the Department of Health (DOH) then the Department of Health & Social Services, and it is now back to the Department of Health (now DH). Recently the British NHS has fragmented into English, Welsh, Scottish and Northern Irish services, with distinctive differences which are likely to increase in the future.

The original structure was a powerful Regional Health Authority supervising Hospital Management Committees. These latter were later supplanted by AHA's and sub-ordinate Health Districts or Sectors, themselves subsequently replaced by District Health Authorities and then by Trusts and now by Foundation Trusts. The old RHA was replaced by the much weaker local Strategic Health Authorities, but now these SHA's have resumed the larger territories of the old RHA but with much diminished power. Mercifully the new SHA's seem to be co-terminous with the postgraduate deaneries.

What does all this mean for the hospital consultant? My P60 tax certificates tell me in 1981 I was employed by the Northern Regional Health Authority. In 1993 I was employed by the South West Durham Health Authority, in 1994 by the South Durham Health Authority, in 1995 by Bishop Auckland General Hospital Trust, in 1999 by South Durham Health Care, in 2003 by County Durham & Darlington Acute Hospitals Trust, and in 2007 by County Durham & Darlington Foundation Trust. Over a period of 26 years in what has been largely the same job I have had 7 different employers and 8 different local managers, variously called Sector Administrator, Unit General Manager, and Chief Executive. The implications are that managers and structures change rapidly, and it is often up to the clinician to take the long term view on the organisation of services and the contents of their job.

Along the way the NHS has acquired charges for prescriptions, and eye and dental services. Hotel charges for TV, phones and car parking are now general, though basically treatment remains free at the time of need.

We have had various initiatives including Resource Management, the Purchaser Provider Split, GP Fund Holding, the Private Finance Initiative, Practice-Based Commissioning, Primary Care Trusts, Choose & Book appointments (now Direct Booking Service), Cancer 2 week wait rules and Independent Sector Treatment Centres. These innovations are often introduced without validation, in response to specific problems and are often abandoned when they are seen to be ineffective. We have largely lost out-of-hours GP care. The NHS Direct phone service seems to have created additional demand for advice and services rather than replacing established requirements for medical care.

However, the NHS is our most popular British institution, embodying cherished ideas of fairness, dedication and triumph over adversity. It is seen to provide security of medical care for the population. Despite the bad news bears of the press it is known that health care is improving with better outcomes. Its lack of perfection is a perversely endearing feature. It is ironic that the Labour Party in 2007 should be less trusted in opinion polls than the opposition to preserve its traditions considering the dramatic increase in funding over the last 10 years. It is hoped that the latest Review recognises the value for money it represents, and the destructive possibilities inherent in deliberately building up private facilities to the detriment of local NHS provision.

Despite recent problems the NHS generally offers unrivalled security of employment for doctors and has a tradition of guaranteeing careers for UK graduates. Many non-clinical NHS employees cheerfully work long hours for small wages because they believe in the system. It would be bound to be different and a good deal less committed in a fully commercial environment.

The USA has some of the best health care facilities in the world, and selective vision convinced Margaret Thatcher this was a model to copy. It also has some of the very worst provision. At least 45 million of the population there has no access to routine health care under the American insurance system and it is dealt with by pauper crisis management in hospital. With the widening gulf between rich and poor in Britain one could easily see that the problem could be reproduced here if we do not vigorously defend the NHS.

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AGM

THE ANNUAL GENERAL MEETING, CONFERENCE and DINNER 2007

SATURDAY, 6th OCTOBER

at FRIENDS MEETING HOUSE, EUSTON RD, LONDON
and the AMBASSADORS HOTEL, Upper Woburn Place.

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