

Spring 2006

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What sort of health service do we want to see?

Editorial

For a number of years the SHA has concentrated on public health questions and neglected health care, but the last two meetings of Central Council have been dominated by discussions relating to the Keep Our NHS Public campaign. So this issue of S&H takes us back to the original roots of the organisation. What sort of health service do we want?

Inside you will find a survey. We want to know which issues are most important to our members. We also include a discussion paper by John Lipetz on the need for organisational changes in the NHS. We are planning to produce a document outlining our vision for the future of the NHS. This will go to the Keep Our NHS Public campaign. We think their campaign needs to be more positive. If we don't like everything the Government is doing we need to propose an alternative. The paper will also go to the Labour Party National Policy Forum. The process of developing the manifesto for the next General election has started and we want to play an active part in it.

It is our members in England who are most unhappy with the introduction of a market economy in health, but we need everyone to respond to our survey. We want to know what you think is good and bad in your local NHS and how you want to see the service develop.

A NEW MODEL FOR LOCAL DEMOCRACY; OR TAKING POLITICS OUT OF COMMUNITY LEADERSHIP

Paul Walker, Chair

At a recent Conference about empowering communities I had cause to reflect on my time as a City Councillor where empowering communities was, for me, a key role and a major interest. I say "for me" because it was rather obvious that other councillors did not see their roles in similar terms, particularly the Labour ones.

It was my experience that communities and particularly disadvantaged

ones were crying out for leaders to help them

achieve empowerment; and that councillors could play an important role in this – not necessarily, or even desirably, as community leaders

themselves but as facilitators and supporters of such leaders from within the community itself. This being so what, I ask myself, is the point of a councillor having a political party affiliation? This question seems all the more pertinent now than it did when I was a councillor because I have just spent 3 years working in two rural counties in Wales where most councillors are Independents.

What is needed for the community leadership / support role is someone from the community with a track record of local community service and community interest. Not some party nominee parachuted in from distant parts charged with winning the ward

to ensure overall control by that party at city/borough level. Which was exactly what happened with me.

It is my contention that traditional party politics is not relevant at community level. Local ward elections should be non political – candidates being judged purely on their own record, not on their party affiliation.

This does not mean that candidates should not be party members, only that such membership should not be a material consideration to their candidacy, merely an incidental like church affiliation or ethnic origin.

What about at municipal / county level? Here I think party politics begins to have some meaning so one of the qualifications for election to fulfil the essentially policy and strategic role at this level should continue to be a declared party affiliation. Not the only qualification because fulfilling this role requires very particular attributes.

So how could one retain party politics at cabinet level while depoliticising the ward leadership role? Perhaps by having two councillors for each ward, one an independent with a local community leadership role plus a scrutiny type role at municipal/county level; and the other, with a party label, having a municipal role involved in strategy and policy development. The former would have an important secondary role in explaining and representing community needs at municipal level; and the latter would have a reverse role explaining and representing municipal policy and strategy to the community. To have two local elected representatives with different but complementary roles would be a great improvement on the current arrange-



Better information needed to help Scots exercise their NHS rights

Scottish Consumer Council

A nationwide survey has found that most Scots have a very patchy knowledge of the rights they have in relation to their health. They are unaware of how their personal health information is stored and shared, and have little knowledge of 'rights' created by Scottish Executive policy developments.

The survey, conducted on behalf of the Scottish Consumer Council (SCC) found that almost two thirds of people (64%) were unaware they can have a say in which hospital they go to for treatment, and more than three quarters (79%) did not know that they could be involved in decisions about which consultant they would see.

The survey has uncovered real gaps in knowledge and understanding about these and other health rights. The implications are serious – if people do not know about their rights, they will not get the benefits that these rights can give them. The report calls on the Scottish Executive to ensure that people have the information they need to make meaningful use of their rights.

The survey was conducted among a representative sample of 1000 people across Scotland. It found that people knew more about the rights they had in using primary care services. Around half knew that GP surgeries should be providing advice or an appointment within 48 hours. However, far fewer people were aware of their rights when it came to hospital services.

There was also a poor level of knowledge and awareness of

rights about NHS policy developments such as the right to be involved in choosing which consultant treats you, even among people who considered themselves generally well informed. This suggests there is a need for better information to be provided to the public about such policy initiatives.

People in the 45-64 age group appeared to be the best informed and were the most confident about being able to find the information they needed about their health rights. Unemployed people were among the least well-informed despite being some of the heaviest users of health services.

One particularly surprising finding was the low level of awareness of how people's personal health information could be used and shared, both within the NHS, and outside it. Almost half of those interviewed incorrectly believed that information about their health could be passed to the Benefits Agency, and almost a quarter did not know whether this was true. The report recommends that the Scottish Health Council should monitor how effectively patients are being informed about how their personal health information is being held and shared.

The report says it is important to improve awareness of where people can find information about their health rights. Two thirds of the people who responded to the survey said they would seek information from their GP surgery. The SCC says the Executive should examine how GP surgeries could be encouraged to

help patients access information about their rights, possibly in collaboration with Citizen Advice Bureaux.

Graeme Millar, chairman of the SCC said: "This research shows that while most people know quite a lot about some aspects of their rights, they are quite uninformed about others. Unless people know what their rights are in using the services of the NHS, it is unlikely that they will be able to benefit from them.

We hope the concerns raised in this report will be addressed constructively by the Scottish Executive and by other organisations working with the NHS in Scotland, so that patients can increasingly take more responsibility for their own health and make informed choices about their healthcare."

About the Scottish Consumer Council

The Scottish Consumer Council was set up by the government in 1975 to promote the interests of consumers, particularly those who experience disadvantage in society. While producers and suppliers of goods and services are usually well organised when protecting their own interests, individual consumers very often are not. The people we represent are consumers of all kinds: they may be council tenants, patients, parents, solicitors' clients, public transport users, or simply shoppers in a supermarket. We speak up for them by communicating with the professions, industry, business, local authorities and central government, using careful research and persuasive lobbying.

ON BEING A PATIENT AS WELL AS A GOVERNOR

Sir Richard Knowles

I serve on the Governing Body of the University Hospital Birmingham NHS Foundation Trust as one of the two Public Governors representing Edgbaston. My colleague, Mr Jeff Oates, who got two more votes than me, is a retired surgeon. Our Foundation Trust is an integral part of the NHS but is different in that it is run on the lines of a co-operative owned by its members, and is therefore more locally controlled. The Governors, who serve in a voluntary capacity, appoint the Board of Directors, who actually run the hospital under the chairmanship of John Charlton.

One of the advantages of reaching the tender age of 89 is that you are more likely to use the health service than when you are 29. That has been my experience and has given me a personal insight into the service that users are getting and maybe enhanced any contribution that I might make at a Board Meeting.

One should be clear. All of us rely at first on our family doctor, and Dr Gavin Ralston of the Lordswood practice, where I have been a patient for thirty years or so, is a man with whom one has implicit trust. All the nonsense about "patient choice" which newspapers, commentators, politicians and ministers "chunter" on

about are as nothing if Gavin says "Mr Spychel at the City Hospital is the best bloke for your hernia" I would rather rely on him than on some pundit on the web who suggests that some surgeon in Stoke-on-Trent or London might be better.

We are told that experts advising HM Government are costing more than the reported deficit of the NHS. I am not surprised for, over the years, I have found that experts and monitors, auditors and accountants, may well have an encyclopaedic knowledge of the price of most things (including their own large fees), but the real value of very little. Therefore it is understandable that their fees have cost more than the supposed deficits of the health service. Of course books have to balance, but over sixty years of politics and organisation has convinced me that most of the experts who have interviewed me over the years knew less about the subject than I did. But I digress.

Turning to the services from University Hospital Trust, which have kept this ancient body of mine on the go. My cataract operation by Mr Burden has enabled me to read eight-point type for the first time for years. The digital hearing aid enables me to hear the drivel talked at

many meetings. Mr Fielding is dealing with the "piles on the posterior of the proletariat", or more possibly "haemorrhoids on the arses of the aristocracy", with humour and political banter. Dr Gompertz and his team are coping with the asthma which I have had since 1924 and which Dr Hallam, a country doctor in Kent in 1937, prescribed smoking a pipe to clear my tubes (I gave up three years ago). Dr Jubb and his colleagues are doing what they can for rheumatics: gout, arthritis and all that goes with walking about like a ruptured duck.

My thanks to all of them and to the nurses, technicians and admin staff all of whom are helpful and cheerful and all of them elated at the prospect of the new hospital, which in the best tradition of Birmingham will be built on time and, near enough at cost.

All in all the hospital is working well and, thank goodness, we are being allowed to run it from Birmingham and not by faceless wonders from Whitehall.

Dick Knowles, along with Denis Healey and Michael Foot, is one of the few still around who attended the 1945 Annual Conference of the Labour Party as a 28-year-old trade unionist.

Choosing Mental Health. *Richard Marx & Alisdair Cameron*

The Institute for Public Policy Research in conjunction with Rethink recently published a working paper titled “A good choice for Mental Health”, that sets out a future vision for mental health. This innovative piece of work adds to the debate that we need to have around meaningful choice becoming a reality for people with mental health problems and challenging the stereotypical attitudes society holds in relation to mental health.

The Government has presented Choice as the motor of public service modernisation but it could be viewed as an assault on the public sphere. This ideological dispute has obscured the fact that choice means different things to different people. The reality is what choices are on offer and who is doing the choosing. Choice should actually mean the power to make real decisions. The opportunity to potentially choose between four or five providers in mental health is not what mental health service users would see as important. Service users would be more concerned over access to services and types of treatment being offered.

The likelihood is that Mental Health will be left to a demoralised and pressurised NHS, with support from the voluntary/community sector, while significant sums of public money will be diverted into the pockets of shareholders of the corporations that have already made inroads into routine and relatively predictable treatments and procedures.

Competition, which brought fragmentation, dislocation and widened inequalities under the Tories, is coming back as “payment by results”. A more realistic title might be “payment by activity”, which is markedly different from any

examination of actual outcomes, especially when, as is the case in mental health, such outcomes are less amenable to crude numerical or statistical measurement.

The problem traditionally in mental health services has been little or no choice available to people with mental health problems. The mental health system has been lacking in the allocation of resources and the need for flexibility to provide a service tailored to needs and wishes of the service user. The reality for most service users is the coercive element of mental health services dominates their actual personal experience. The proposed New Draft Mental Health Bill will impact on how professionals relate to service users, how individuals relate to mental health services and how society relates to mental health.

Mental health care is unique in that choice will present a major challenge to the day-to-day practice of professionals. In the future the ethos of mental health services need to be built around the rights and choices of the service user. It is fundamentally important that people with mental health problems like any other citizen should have the right to make decisions about treatment and life choices. Choices in health and social care should be based on the mix and type of treatment available. The choices available to people should include talking therapies, different kinds of medication, art/exercise on prescription, complementary therapies, directions to local community/support groups. True choice would also allow a service user to exercise the right to modify their treatment or care further down the line, as circumstances change, which means that they should not be restricted by any early

or initial choice that they may make. The need is therefore for Health and social care services to allow such flexibility. This becomes even more crucial once it is realised that some individuals, with good intentions, will nonetheless make bad or inappropriate choices for their care, a scenario that the Government seems to overlook.

The application of choice covers the broad spectrum of mental health services. Even though everyone since 1948 has had a choice of GP this is no guarantee of personally responsive services. Therefore a radical option would be that the GP should no longer be the sole gatekeeper into services; instead new ways to access mental health services should be available through different types of worker. This would also lighten the loads of GPs and allow for less of a plain medical approach, which is all that many GPs can offer, given the demands on their time. If choice is to become a reality, certain changes need to be put in place. First of all further resources: to increase capacity within mental health services, to encourage change in the attitudes of professionals, and to broaden the roles for professionals and advocates to support choice and good information. Furthermore, current use of resources needs to better reflect the user’s preferences and the high levels of unmet need for certain treatments such as talking therapies.

The policy of Government needs to reflect the service user’s instinctive understanding of making choices, choices over their everyday life and plans for the future. If choice in mental health is to be reality it will depend upon making a success of social inclusion.

Lump sum needed by Tim Root From Community Care 18 May 2006

The positive messages taken from Sure Start Plus pilots for pregnant teenagers need to be rolled out nationally to improve unborn babies' well-being, says Tim Root, but that will entail more investment

In April the pilot phase of the Sure Start Plus programme for pregnant teenagers ended. Last year's official evaluation bestowed exceptional praise, finding that clients "were almost entirely positive" about the scheme. It boosted their emotional well-being, helped them preserve fragile family ties, obtain housing and benefits, and continue in education.

At a time when many clients felt overwhelmed, the scheme's warm and empathic advisers were invaluable. One client said: "I don't know what I'd have done without her." The government's Independent Advisory Group on Teenage Pregnancy considered it "crucial that the many valuable elements of Sure Start Plus are retained and mainstreamed" throughout England. The government responded that this is a matter for local decision-making.

I asked national organisations whether they thought equivalent services for all pregnant teenagers would be provided throughout the country. All thought it would be worthwhile, but unlikely. Our antenatal services are seriously underresourced, partly because acute health services attract more interest. The national evaluation of maternity provision in Sure Start (for women of all ages) described how staff shortages in maternity services hamper their ability to help Sure Start antenatal programmes.

Through children's centres, the government plans to extend Sure Start's coverage five-fold, but with only double the funding. Teenagers and other disadvantaged women, particularly those from Bangladeshi and Pakistani backgrounds, have low antenatal care attendance rates. Britain has a higher rate of low birthweight babies than most western European nations. Therefore I also asked the organisations how likely Sure Start would be to provide enough support for pregnant women at risk of having a low birthweight baby, with post-natal depression, and not accessing antenatal care sufficiently.

Most organisations thought this was only slightly likely. The Royal College of Obstetricians and Gynaecologists referred to major concerns relating to the adequate funding of maternity services. The National Childbirth Trust was concerned about the small funding allocation to roll out Sure Start.

Antenatal services can offset many unborn babies' disadvantages and potentially reduce deprivation. A large US study found that women who received no antenatal care were nearly six times more likely than other mothers to have a very low birthweight baby, and the infant mortality rate was five times greater.

A large study of British children found that those of low birthweight ceased education earlier and had lower earnings and poorer job prospects at age 33. Other evidence shows that low birthweight weakens children's cognitive development, even after smoking in pregnancy

and various socio-economic factors, including the mother's education level, are considered. It also leads to an increased incidence of disease in later life. Low income, relatively poor health and smoking during pregnancy all contribute independently to low birthweight. In addition, maternal stress impairs foetal growth and immune system development.

One major advantage of early antenatal care is the detection and treatment of sexually transmitted infections (STIs), which can otherwise cause problems including prematurity and consequent lowered birthweight. The greater prevalence of STIs among teenagers than older women is an important reason for improving teenagers' antenatal care attendance. Many pregnant teenagers are uncomfortable attending antenatal care, feeling that they will be judged negatively by older patients and staff. Some areas have set up separate teenage antenatal clinics, which an Australian study found significantly reduced the rate of pre-term birth.

A major cause of low birthweight is inadequate nutrition during pregnancy. A US programme giving poor pregnant women \$35 (£20) worth of nutritious food a month made them less likely to give birth to an underweight or premature baby than other women. This achieved health savings which easily outweighed the cost of the programme. By comparison, the government's new Healthy Start scheme will provide vouchers for fruit, vegetables or milk worth only £2.80 a week, restricted to pregnant women on income support or in-

come-based job-seekers allowance. As well as improving Healthy Start, public transport should be free during pregnancy to encourage antenatal care attendance.

The other major risk factor for low birthweight is smoking. Nearly half of women under 20 do so during pregnancy. Controlled trials found that the most successful schemes to quit smoking during pregnancy use financial reward and an element of social support. The NHS should start to offer a reward element. This would motivate some women who would otherwise recoil from the challenge of stopping smoking at such a demanding time.

More evidence is emerging that stress during pregnancy harms children's long-term mental development. A Bristol University study found that, even when birthweight, smoking and alcohol use in pregnancy, maternal age and education and other factors were considered, antenatal anxiety doubled the likelihood of children having behavioural or emotional problems. It was the strongest factor in relation to girls' behavioural or emotional problems, and second strongest for boys.

In view of the harm stress causes, and the particularly anxiety-provoking nature of pregnancy, it is not surprising that programmes providing emotional and social support during pregnancy have proved effective. One well-evaluated US programme for disadvantaged women, starting before 28 weeks' gestation and continuing until the child reached two, reduced abuse and neglect, and health or accidental injury problems among the children. It also boosted birthweight,

though in one trial only among single rather than married women. A similar programme found that the mothers were more responsive to their children and gave them more freedom to play than comparable mothers.

It is also important to note that depression or stress during pregnancy and little social support are risk factors for post-natal depression. The only officially prescribed response to women deemed at high risk of post-natal depression is psychiatric referral. But, due to stigma and the other demands of pregnancy, few women would welcome such a referral. Many Sure Start local programmes run groups for women at risk of post-natal depression but do not refer to them thus. They provide mutual support and relaxing activities, such as swimming and holistic therapies. This suggests that massage would be a popular therapy for such women; research shows that it reduces depression, stress hormone levels and pain while boosting serotonin, which is understood to play a role in regulating mood.

Prime minister Tony Blair has emphasised the cost-effectiveness of helping children long before their problems become entrenched. Improved antenatal services could achieve this.

TIM ROOT is a senior practitioner with Hackney social services' children and families, and previously an assistant team manager and approved social worker. He is the author of *Love, Empowerment and Social Justice: Personal Relationships and Citizen Action*, Open Gate Press, 2005

COMMISSIONING GUIDANCE MEANS MORE POWER FOR PATIENTS

Press release dated 14th July 2006

Patients are to be given more power to influence the way their local health services are organised and run. New plans from the Department of Health will mean Primary Care Trusts will be required formally to respond to petitions from the public if more than one person in a hundred in the community is unhappy with a particular health service.

The Health Secretary, Patricia Hewitt, has also announced new arrangements for organised patient involvement. The changes are designed to build on existing Patient Forums by setting up new Local Involvement Networks, to be called LINKs, which will have more clout to influence services in hospitals and in the community. The proposal is central to new guidance being issued to the NHS on commissioning services.

The guidance, "Health Reform in England: Update and Commissioning Framework", details five objectives towards which Trusts will have to work with local clinicians. They are improving health and well-being and reducing health inequalities, securing access to a comprehensive range of services, improving the quality and efficiency of services, increasing patient choice and ensuring greater responsiveness to needs and achieving best value. In delivering on each of these PCTs it will be required to involve patients in the organisation of services. They will have to publish documents covering the assessment of local needs, the quality of services, patient satisfaction levels and future investment plans.

Patricia Hewitt said she was determined to give patients and the public a bigger say in their local health services. "People increasingly want to become active partners in their own health care and we need to create a system where people are no longer passive recipients of NHS and social care services but are able to shape them to suit their needs," she said.

What sort of National Health Service do we want?

Martin Rathfelder

The Blair Government's continual reforms of the NHS have created a climate of uncertainty which probably for the first time in many years has given the Conservative Party a lead in polling questions about health. Keep Our NHS Public is just one protest organisation which is prospering in this climate of anxiety. A clear vision of the future direction is urgently needed and Blair's continued demand for reform at all costs will not do.

There was never a golden age in the NHS and all sensible commentators agree that some reform is necessary. But reform is not an end in itself. And the capacity of the health service to cope with repeated reform was exceeded some time ago. Staff are not impressed when they find that the organisation for which they work has been abolished six times in fifteen years without any obvious effect on the problems they have to face every day, but a great deal of wasteful expenditure in repainting the signs and printing new notepaper.

We want to develop a vision for the future of the NHS which will attract support inside the Labour Party and harness the energies currently devoted to Keep Our NHS Public and other organisations of people concerned with the fu-

ture of the NHS. We want you to help us to produce this vision.

Process

We present here a series of fairly simple statements of policy. We want to know if you agree with them. Those which we think there may be disagreement about within the SHA have a rating bar attached. The others are statements we think most members would agree with – but please tell us if we are wrong. They are not all consistent with each other, and some are more important than others. There might be other issues you would want to raise.

Once we have heard back from our members – and some of our comrades in other organisations – we will endeavour to construct a concise document encapsulating our vision of the future of the NHS which we can present to the Labour Party and other organisations such as KONP

Political perspective

1. We still believe that keeping the Labour Party in power represents the best political option for developing the sort of health service we want to see. We do not support campaigns which undermine Labour's support.

<i>Agree</i>		<i>Disagree</i>		
1	2	3	4	5

Public Health

2. Prevention of ill health is more important than the provision of health care and that needs to be tackled largely outside the NHS

3. The reduction of health inequality is very important to us. We want to see a substantial shift of health resources to the most deprived areas, and we accept that this will generate protests in more prosperous areas which have had more than their fair share in the past

4. Economic regeneration is critical to the reduction of health inequality.

5. On its own diverting resources to the poor is not sufficient. We need to reduce the level of inequality in our society so that the gap between the rich and the poor is reduced.

6. Education and employment are more important than health services in reducing health inequality. We cannot go on pouring resources into the NHS and neglect everything else. We do not want to see the level of resources devoted to health-care continue to rise faster than GDP.

<i>Agree</i>		<i>Disagree</i>		
1	2	3	4	5

7. Prevention is better than cure. We want to see real emphasis on reduction of sexually transmitted disease and more exten-

sive vaccination with a rigorous evaluation of the cost effectiveness of these services in comparison with other services which are treated as higher priority in the absence of evidence of cost effectiveness.

8. To enable disadvantaged people to take as much advantage of the NHS as those more prosperous we need much better information and advice systems.

Decision making

9. We want to see decision making in health devolved to local democratically elected bodies as it is in social care. We accept that this will mean differences in services from one area to another. The most obvious way of doing this would be to give the commissioning responsibilities of PCTs to local authorities, but we would be interested in discussing other possible options.

10. There should be proper arrangements for comparing the advantages and disadvantages of different healthcare systems across the UK, and in particular the advantages/disadvantages of direct commissioning should be rigorously evaluated in the light of Scottish experience and the recent Kerr Report on the new NHS management arrangements in Scotland.

11. We may need a new debate about what services the NHS should provide in the light of technological developments. This

might be called rationing. It is important that any decisions in this area relate to existing treatments, some of which have poor evidence of cost effectiveness, as well as new treatments.

<i>Agree</i>		<i>Disagree</i>		
1	2	3	4	5

12. Public finance should remain in control of those who are publicly accountable.

13. Healthcare organisations should be required like everyone else to balance their books at the end of the year. Their accounts should be open and transparent.

14. Every contract and tender with the NHS should be available for public scrutiny. Selection procedures for providers should be open and include public representation.

15. There should be a clear specification for any services outsourced, their objectives and evaluation criteria. Contracts should be not longer than three years and should be subject to annual review with performance data in the public domain.

NHS services

16. The NHS should be free at the point of need. The charges that are still made for prescriptions must be abolished. We are not convinced that it is sensible to continue to isolate social care which is chargeable from healthcare which is free.

17. It is important to

continue to improve the service provided by the NHS. A reduction in overall waiting between presenting with a problem and the start of treatment to 18 weeks will have enormous political consequences, and should be pursued despite the difficulties it will generate.

18. The shift of resources from hospitals to primary care is to be applauded. Closing wards and hospitals is a necessary part of this and needs to be done.

19. There has been too much emphasis on cold surgery. Reducing delay and improving choices for people with acute and chronic medical conditions, and in mental health and childbirth needs a lot more emphasis

20. We think the public sector ethos, comprising among other things, compassion, pride in ones work, selflessness and a feeling of belonging to a worthwhile and much valued organization, is distinctly different to that of the private for profit sector and it is worth retaining and developing because in the end it represents added value to the service delivered to the patient / user.

21. Every healthcare provider should demonstrate clear value for money, and provide services which are perceived to be of high quality by the people receiving them. Private providers are inherently more expensive than NHS organisations because of the need to generate a profit. We would want to

be assured that any private providers offer better value for money than an NHS provider.

22. We have no objection to private sector providers being introduced if they can demonstrate that they will deliver a better service than NHS providers. We do not think most commercial organisations can do this without unfairly exploiting their position.

Agree *Disagree*
1 2 3 4 5

23. We do not want to see any further contracts signed between the NHS and commercial care providers. The NHS should develop services to take the place of those services currently provided by commercial organisations.

Agree *Disagree*
1 2 3 4 5

24. We want to see more locally run locally accountable not for profit services in the NHS providing services which traditionally run NHS organisations have not provided successfully.

Agree *Disagree*
1 2 3 4 5

25. If there is to be real plurality then the NHS should provide substantial support to those aspiring to create innovative organisational models including social enterprise bodies.

26. We see no need for more independent sector treatment centres. If their competition was necessary to get waiting lists down then it has had its effect.

27. Building surgical centres away from hospitals is a mistake. When there is an epidemic we will need all the beds we can get.

28. There are too many hospitals and too many beds in most parts of the UK. We can and should provide much more care closer to people's homes.

Agree *Disagree*
1 2 3 4 5

29. PFI has served its purpose in getting hospitals built, but we can't afford any more PFI schemes.

30. We cannot justify building more hospital facilities to increase choice if that means that some organisations have to be paid to stand empty.

Agree *Disagree*
1 2 3 4 5

31. Payment by results will only work in services where there are clearly definable results. It seems unlikely to work in mental health where there is disagreement about diagnostic criteria, nor in care of the elderly where the patients eventually all die. It contains inherent incentives to over treat and equally clear incentives to avoid taking on complicated cases. Rushing to impose it on the whole NHS is a big mistake.

32. There should be a moratorium on nationally mandated structural change for at least 10 years – this would not preclude local changes in hos-

pital or other service configurations to meet locally agreed needs; nor would it preclude locally ie regionally, agreed structural changes that were regionally agreed as being desirable.

33. We strongly support the current moves to improve the care of those with chronic illnesses – one of the keys to this is the roll out of the Unified Assessment Process.

34. Cooperation and integration of services are the keys to providing effective packages of care, not competition and choice which inevitably operate in the opposite direction. A single electronic patient held healthcare / care record is crucial to achieving effective cooperation and integration. With active management of patients in and out of hospital considerable reduction in hospital stays can and should be achieved.

35. We want to see an integrated system based on planning and cooperation rather than competition and fragmentation

Agree *Disagree*
1 2 3 4 5

Please send you views, either by email or post to the SHA office. You can mark this article if that is most convenient, or just let us know which of these statements you agree or disagree with.

And of course you may want to make additional points. If you reply by the end of August we should be able to take your contribution into account when we write our paper

National Health Service: Organisational Issues

John Lipetz

Introduction: Context

The NHS is the largest organisation in Europe with the task of producing complex health and people outcomes.

There is no doubt that huge strides have been made in the quality of patient care and in the speed and efficiency of providing diagnosis and treatment to people whose demands and expectations of the service continue to increase. But much remains to be done.

The current debate is on the issue of whether the NHS should remain under public control. This is taking place at a time when the NHS is going through yet another bout of structural change. But structure by itself is not an answer to organisational issues. Is it healthy to have so much micro-management at national level, invariably reacting adversely on government? In this volatile climate it is not enough for the SHA to establish a view, whether supportive or not, of our labour government's approach. We need to establish an agreed approach on how we believe the NHS should be run, derived from the recently agreed statement setting out our mission, core values and aims. Hence this paper.

Strategic Direction

It is the role of government to give strategic direction to the NHS by providing a broad policy framework containing its key priorities and setting out the objectives and standards to be achieved. The NHS should have the distinctive and separate role of delivering the objectives set to the required standards. It is the government's task to hold it to account. Clearly these roles are different although both the formation and implementation of policy and objectives should be matters of continuing dialogue between the DoH and the NHS Executive. It was our labour government's mistake to combine the two roles.

Given this delineation of roles and process the main tasks of the NHS Executive at national level is to carry out all matters impinging on the provision of an efficient and effective service. It can then concentrate on giving direction to operational matters both in the short and longer term. This should not undermine the need for local variations to meet local circumstances.

Some Questions on Organisation

The question to be asked is "are the present arrangements appropriate for the task in hand?" Whilst it is necessary to oversee the delivery of health care in hospitals and the community it is doubtful whether the purchaser provider model is appropriate or achieves results. This is compounded by the extension to commissioning to establish competitive providers both in the public and private sectors.

Clear systems are necessary to ensure that the direction on operational matters is consistent and soundly based. Certain functions have to be effectively organised in any large organisation. The main ones are finance, human resources, provisioning and information systems. Those specific to health care include public health and clinical governance. How these functions are coordinated and delivered at each level of the organisation is critical to its efficiency and effectiveness.

We have to start from where we are. Take finance. The extra funding has to be effectively managed and controlled. Extra money for additional doctors and nurses has to be welcomed. Staff pay increases were desirable in general although the new contracts for consultants and, particularly, GPs seem to be over-generous without obtaining adequate returns. Substantial sums are now required to pay for transaction costs arising from the introduction of the market and for the enhanced payments made for private provision. And for Trusts with PFI schemes there are large sums to be paid out of revenue budgets over many years in order to service the contracts. The tariffs set under the recently implemented payment by results system appear not to reflect the real cost and the differing complexity of care between conditions. Obviously, robust financial controls are necessary. But what form should they take?

Human resources include manpower planning, training and development of staff and pay and conditions. How much these aspects are coordinated across the service is debatable. Are we meeting, for example, the short term needs for technicians and the longer term needs for specialist consultants? How much talent are we developing internally? Are our short and long term recruitment plans adequate?

On provisioning, are we using the purchasing power of the NHS to the fullest extent and in the most effective way? At what level are contracts entered

Page 12 into? Are our storage and distribution systems the most efficient?

Are the NHS information systems fit for purpose? What statistics need to be collected at local and national level on a daily, weekly and monthly basis? Who holds the responsibility at each level? Is the investment in much needed IT systems well used?

Are the systems of local management the most effective? How do we ensure proper clinical decision making? Should consultants not have contracts with the NHS as a whole rather than with individual trusts, given that many have part-time posts with different units? What is the right balance between managers and clinicians in the running of hospitals?

These are only some of the questions that need to be put. But they indicate the importance of having in place coherent organisational systems to deliver effective health care to the population. It is probably the case that a somewhat different system should be applied in the primary and community care sector from that appropriate to the secondary sector. The former has to work closely with partners such as local authorities and voluntary and independent bodies.

The NHS Organisation We Need

It is said that the old command and control model is outmoded. Given the current dangers of fragmentation that pervade the NHS this is doubtful. But it does not need to be 'top down', nor should it be. It is relevant to examine where responsibility lies and how coherence can be reintroduced. The section above on strategic direction indicates the first major step in the process. We can then consider how the NHS should be most effectively organised.

There is a need for a strong national presence covering all the main functions that need to be exercised. Each department needs to have a team strong enough to deliver its area of competence. These departments should be brought together in a way that enables them to relate to each other's specialism and their heads meet regularly as a management group.

Given the size of the NHS there is clearly a need for a regional structure of some form that might well coincide with Strategic Health Authority level. What is not suggested is any further re-structuring. But the civil servant input should remain at national level and be confined to the DoH.

It is the way that the national, regional and local levels work together that is the key to effective organisation. Each department or function should have regular meetings to discuss progress and take into account views at all levels. In particular, these

should take place regularly between national and regional levels as well as between regional and local levels. It is only in this way that the expertise and experience existing throughout the NHS can be brought to bear.

The NHS has endemic problems. There is the "re-inventing the wheel" syndrome whereby people at local level are left to develop new systems/methods for the same purpose in different areas. This is a waste of bright managers' efforts. The reliance on "consultants" (whose responsibilities cease immediately after input) to deal with perceived problems should be avoided or at least substantially reduced. The use of outside bodies to run conferences at high cost, rather than doing this in-house, should be limited.

The public sector ethos should be cherished as an immeasurable asset. Involving the workforce at all levels and valuing their contribution enhances our effectiveness in the delivery of health care. It should be management from the bottom up, not top down. These are values to which the SHA holds.

Conclusions and Recommendations

This paper does not attempt to be comprehensive. It addresses some of the evident deficiencies in the management of the NHS. The issues are complex and there are no easy answers. It does not set out a complete prescription for these problems. It is hoped that members who have experience of different aspects of organisation will be able to make useful contributions on this issue. Let us hope that an agreed set of principles applicable to NHS organisation can be reached.

The guiding principles could include establishing the most appropriate level of management at which each decision is made and operation is carried out. The balance between management support and instruction should be clarified so that staff at all levels are used effectively. Most activities should be carried out in-house rather than contracted out, to ensure effective control and greater worker commitment. Involvement of staff at all levels ensures commitment and reinforces the public sector ethos. Priorities - the language of socialism! - should be applied rather than the overuse of targets.

This paper should lead to discussion and debate within the SHA and beyond. We need to have a firm view on what is needed.

Britain needs a national health service that is well run in order to provide quality care where and when it is needed based on sound principles of public service, as originally envisaged both by our predecessors in the SMA and by the Labour government when it was established.

The David Stark Murray Trust

Dr David Stark Murray was President of the Socialist Medical Association from 1951-1972, and editor of *Socialism and Health* from 1930-1972.

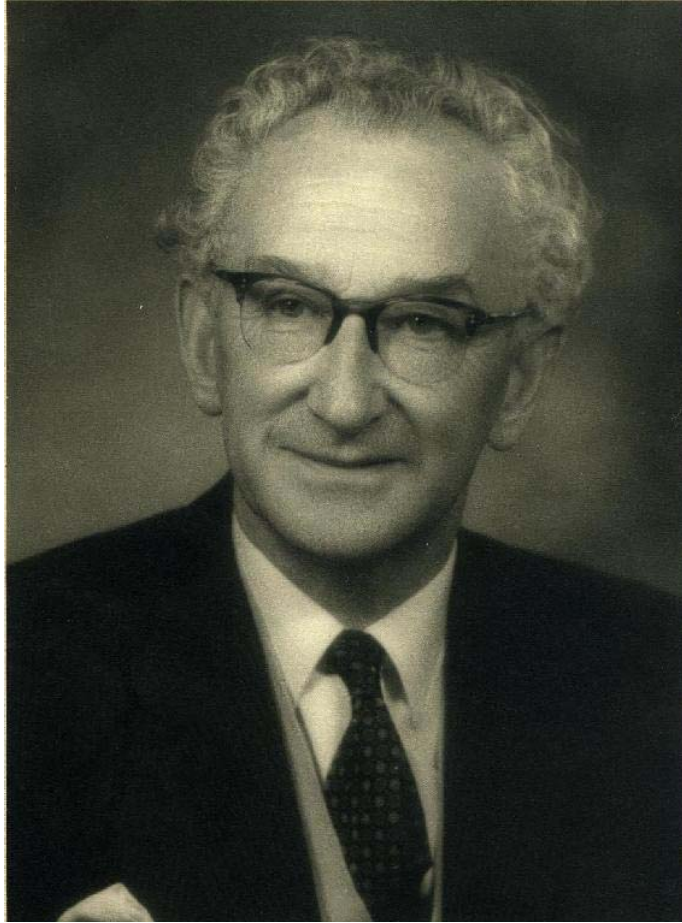
David was born at Barhead, Scotland, and qualified in 1925 from Glasgow University. He decided at the outset that pathology was to be his chosen field and first came to London in 1927 as pathologist to the Lambeth Hospital under the old Board of Guardians.

Soon after coming to London, David became associated with Somerville Hastings, Charles Brook and others in the State Medical Service Association, formed in 1912, whose programme included the organisation of the medical profession as a state service, each member to be paid by salary, the nationalisation of all hospitals and the service to be available to every man, woman and child.

In September 1930, at a meeting organised by these three doctors and presided over by Esther Rickards, a new body of socialist doctors was formed, which became entitled the Socialist Medical Association, affiliated to and exercising its influence through the Labour Party. The fascinating history of this period, and the subsequent story of the SMA are set out in David's book, 'Why a National Health Service?'

A Trust in his memory was established in 1995 for two purposes:

To advance public education about the social and medical causes of ill health and to conduct, promote and further research into those causes and their effects and to disseminate the results of research to the public.



To educate or promote the education of doctors nurses and other people in the fields of medicine and sociology in the medical psychological and social causes and effects of ill health.

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The registered office is 22 Blair Road Manchester M16 8NS

The Trust supports research particularly into health inequality and supports the dissemination of research into health inequality. We are presently considering whether to sponsor some research into the effect of patient choice on health inequalities

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Many SHA members make regular donations to the association in excess of their subscription. It would be more beneficial if you want to make a donation for you to give money to the Trust, as we can then reclaim the tax you pay.

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Future Events

Labour Party Conference Manchester 24th to 28th September Symposium on Inequality Monday 25th September 12 pm to 8 pm

Friends Meeting House just outside the conference.

Main speakers include:

Prof Sheena Asthana, University of Plymouth; Louise Bamfield, Fabian Society; Karen Buck MP, Labour Housing Group; Prof Danny Dorling, University of Sheffield; Dennis Fernando, National Assembly Against Racism; Sir Gerald Kaufman MP; Neal Lawson, Compass; Madeleine Moon MP; Prof Richard Wilkinson, University of Nottingham Medical School.

The War on Drugs - Another unwinnable American adventure?

Wednesday 25th September 12.45pm Friends' Meeting House

Main speakers: Camilla Cavendish, The Times; Dr Geof Rayner; Dr Paul Walker.

Regulating Healthcare Professionals London Wednesday 11th October 2006

Sarah Thewlis Chief Executive, Nursing & Midwifery Council; Arthur Keefe, member of the General Social Care Council; Carol English Amicus ; Kevin Barron MP, member of the General Medical Council ; Tina Funnell, member of the Neale Enquiry

Developing Labour Health Policy

London Saturday 2nd December 2006

Birmingham Saturday 11th November 2006

Exeter Saturday 28th October

Dates to be arranged in Leeds and Manchester

Developing Labour Health Policy in Scotland

Edinburgh Saturday 4th November 2006

Developing Labour Health Policy in Wales

Cardiff Saturday 7th October 2006

Costs for each of the events above vary but are reduced for SHA members (and delegates from affiliated organisations, such as Amicus and Unison). Some free places for people on means tested benefits.

We provide lunch and cater for vegetarians. If you have any other special needs please let us know. To book a place please ring 0870 013 0065 or email admin@sochealth.co.uk.

Articles, Letters, Announcements and Comments should be sent to the editor Gavin Ross, 21 Connaught Road, Harpenden, Herts AL5 4TW, The deadline for contributions to the Autumn 2006 edition is 30th September. Tel/Fax 01582-715399 or by e-mail to gavros.ross@btopenworld.com

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