White paper whiteout

Mark Aitken

59 High Road, Leavenheath, Suffolk CO6 4PB, UK

E-mail: aitken.petri@btinternet.com

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The recent flurry of white paper activity from the Department of Health[1–3] looks like yet another attempt to invite us to milk those parts of the NHS sacred cow from which milk was never meant to flow.[4] Isn't now the time to unite and synthesize the solution which generations of politicians have failed to deliver? A tough call, particularly when you realize that hospital consultants are not included in the Government's consultative process! It is difficult to know whether our exclusion is because of our previous avaricious expressions of self-interest which preceded the final NHS Act in 1948, or because the Government has understandably forgotten that doctors are supposed to be the champions of healthcare delivery. Either way, we need to get back into the driving seat and, without any preconditions, give this every ounce of energy that our brains can muster.

Decentralization

Decentralization has been a common platform for NHS reform. The main difference between Hospital Trusts and Foundation Hospital Trusts is the necessity to recruit honorary members from the local population and then give them powers to elect representative Governors. Unfortunately Management Boards, sensing a serious challenge to their authority, agreed to 'respect' the opinions of these Governors but stopped short of taking their advice, preferring instead just to use them to rubber stamp the Board's pre-emptive decisions. It is possible that some Trusts might have been more inclusive, but in NE Essex that does not hold good. One presupposes that the perceived risk was that the public tail might wag the corporate dog to death.

One solution would be to balance the public Governors with a clinical body of equal size and authority. We might call this body 'The Clinical Memory Bank'. In that way public aspirations could be matched by pragmatism based on clinical know-how. The downside might be the potential conflicts of interest of practising clinicians relating to their proclivities to empire building and private practice. However, a little lateral thinking could solve that conundrum. Recruit retired local senior clinicians (doctors and nurses). Such a body would not only have >40 years of clinical experience, but also the likelihood of having been on the receiving end. A locally focused body would be unlikely to permit clinical priorities to be out-trumped by financial bullshit. We need real local empowerment not rubber dollies.

Governance

Currently Monitor, the Quality Care Commission, the Strategic Health Authorities (SHAs) and Primary Care Trusts among others, all with their own non-productive bureaucratic agendas, regulate financial prudence and the perceived needs of patients. This conglomerate consumes 14% of the £100 billion spent on healthcare but rather than cutting it out the Coalition proposes to mix and match the existing bureaucrats into a convoluted system with empowerments and constraints. The end result may be very little different from the status quo but it will take us a few years to fathom its foibles.

Perception of need does not follow a universal formula. The aspirations of local communities are different and that difference is not uniformly distributed throughout Britain. Individual communities have their own healthcare objectives. The politicians should respect that diversity and desist from telling us what is best. Why, therefore, is it necessary to have a handful of self-indulgent quangos arguing the toss about who gets what?

Competition

As you wade through this jungle of jargon the word 'competition' pops in and out of view. There are all shades of good and evil in the competitive nature of sport and war, but is there really a place for competition in a service which has more in common with charity than consumerism? With competition there will always be winners and losers. The risk is that the patients will be the losers. Most of the suggested changes to healthcare delivery show that those making these decisions have had no personal inpatient experience of NHS facilities in the sticks. The best judges are likely to be the communities themselves where these preemptive decisions are being made. Isn't that where the locally elected Governors should cast the deciding vote? Competition can drive up standards and increase patient throughput but that competitive spirit has to come from within the hospital. Furthermore, for internal competition to acquire honourable credentials it must distance itself from empire building and direct/indirect financial rewards. The charitable nature of our work should be reward enough.

Targets and the European Working Time Directive

Curiously, neither of these politically imposed impediments to clinical practice was mentioned in the White Paper. Targets have denied the clinical workforce from prioritizing the individual healthcare needs of patients. Changing the A&E compliance target from 98% to 95% completely ignores the irrationality of its original implementation.

By applying the European Working Time Directive (EWTD) to healthcare it was claimed that this would increase the survival of patients and improve the wellbeing of doctors. No government-sponsored audit was set up to assess the validity of these hypotheses. It has now been shown unequivocally that implementation of the EWTD did not increase patient survival but had a devastatingly detrimental effect on junior doctors' health.[5] The blinkered bureaucrats also failed to spot the effect that the EWTD might have on teamwork and continuity of care. The former is now fragmented and the latter has all but gone.[6] Is that not sufficient evidence for our non-evidence based politicians to say sorry?

Action plan

Having dismantled the braking mechanism previously governed by the wisdom of clinical experience, our capitalist masters will surely drive the NHS charabanc over the precipice. This white paper[1] entitled *Liberating the NHS* would be more aptly entitled *Passing the buck and liberating the consciences of those in Government*. Should we respond by withholding all NHS-funded services from MPs and their families until clinical propriety has been restored? In the first instance there needs to be wholehearted engagement even though we have not been invited to contribute to the 'discussion'. Why not scrap Monitor altogether and introduce Clinical Memory Banks. Our consummate wisdom gained from long-term clinical experience must surely outclass the puny intellectual vacillations of Parliamentarians.

References

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5 McIntyre HF, Winfield S, Te HS, Crook D. Implementation of the European Working Time Directive in an NHS trust: impact on patient care and junior doctor welfare. *Clin Med* 2010;**10**:134–7

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