**THE NHS AS A PARTNERSHIP BETWEEN CLINICIANS AND POLITICIANS. A model for a de-centralised and depoliticised NHS true to the principles of its foundation.**

Professor John Fabre MBBS BMedSc PhD
Professor Emeritus
Kings College London
The Strand
London WC2R 2LS
Email: john.fabre@kcl.ac.uk

Brief summaries of this article have appeared in the British Medical Journal (25th April 2015, Volume 350, page 25 <www.bmj.com/contents/350/bmj.h2041>), and the Fabian Review (Autumn 2015, volume 127 number 3, page 6).

This article is available online at <thecircleofmuses.co.uk/medicine>.

Summary. 292 words.
Main text. 12,212 words.
Addenda. 4,386 words.
References. 69 references.

**SUMMARY.**
The NHS remains an admirable institution, but it is in decline, and many feel that they are watching helplessly as it deteriorates and fragments. Government policies (both Labour and Conservative) over the past ~20 years have had devastating effects.

This article provides an analysis of the current state of the NHS, and attempts to provide a comprehensive framework for its future.

For the NHS to enter its second 70 years as a successful medical and social enterprise, it must be a genuine partnership between politicians and clinicians. The foundation for such a partnership should be a clinically strong NHS England Board, with equivalent Boards for the other UK regions. There should also be a national structure for the flow of information, ideas and responsibility.

Poor leadership of the hospital service is one of the most serious issues facing the NHS, but it is largely ignored. The provision of high quality, clinically informed chief executives in each of the several hundred teaching and district general hospitals is a key objective. These chief executives could be key decision-makers both locally in their hospitals, and nationally via a tiered board structure.

General practice is being driven by unrestrained market forces and political pressures into an industrialised service with an impossibly high workload and an unsatisfactory organisational structure. The quality of out-of-hours care is suboptimal, and young doctors are turning away from general practice as a career choice. These are complex problems, and there are currently no credible solutions on offer.

No more reorganisations is the current mantra, but those chanting it are simultaneously implementing massive changes. In any case, without reorganisation of the current situation, the NHS is drifting towards its demise. These proposals are towards a simpler and more stable structure.

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## INTRODUCTION.

The NHS has few if any equals in terms of the ambition of its objective: a comprehensive and excellent health care system delivered to all ~63 million citizens of the United Kingdom, and free at the point of delivery. The high principle on which it was established is that good health is central to the life of every citizen, and that guaranteeing this irrespective of the ability to pay is a social ideal of the utmost value. Virtually everyone, doctors and patients alike, wants the NHS to continue in this vein.

However admirable it remains, and however cost-effective it might be, the NHS is in decline, both as a coherent national structure and as a provider of key clinical services.[1,2] There is a curiously fractured situation between civil servants and politicians on the one hand, and on the other hand the large majority of doctors, nurses and other NHS staff. Morale among doctors, nurses and other staff is low and falling.[3-5] We are like the Lilliputians of Gulliver's Travels, firing our tiny arrows at the colossus that is the NHS, powerless to influence events either as individuals or through national organisations.[6-8] In contrast, the uplifting slogans, the charming logos and the glossy reports emanating from the numerous components of the Department of Health continue to flood us. The huge civil service underpinning health is proceeding with overwhelming confidence in the structure it is administering and without the slightest shred of doubt about the direction in which it is heading.[e.g.9] This situation reflects poorly on how the NHS has developed in recent decades, and does not augur well for its future.

The malaise in the NHS almost certainly has two fundamental causes. The first is political interference because of the electoral popularity of the NHS. Large numbers of votes hang on how well Governments are perceived to be doing with the NHS, with the unfortunate consequence that almost every aspect of the NHS is politicised. Government policies can have devastating effects. Jeremy Hunt has referred to the Labour Government's decision in 2004 to remove out-of-hours responsibility from GPs as an "historic mistake".[10] He is right - it has reduced the quality of out-of-hours care in general practice, and has had a major and ongoing destabilising effect on the hospital service. Many people, including senior Conservative politicians, regard the 2012 Health and Social Care Act as a second "historic mistake",[11] this time by a Conservative/Liberal coalition Government. It is leading to the privatisation and fragmentation of the NHS. The current Conservative government is setting out on two additional historic mistakes (see later).

The second fundamental problem is the lack of clinically informed leadership. Leadership currently involves politicians and civil servants, with little input from doctors and nurses. There is no national structure for the flow of information, ideas and responsibility, which is essential for any large organisation, especially one with more than a million employees and a budget of ~£110 billion. Simon Stevens, the senior manager recently appointed Chief Executive of NHS England, has unbridled enthusiasm for more commissioning, diverse "bottom up" reorganisation at local level, "new" organisational structures, "breaking down" what he perceives to be barriers, the inadequacy of "one size fits all", the triply affirmative "accelerating innovation in new ways of delivering health care", and so on.[12] Mr Stevens is now considering the abolition of list-based general practice - where every individual is registered with a particular practice - even though this has been a cornerstone of the NHS since its inception, and in spite of the fact that the BMA's General Practitioners Committee has stated that this would put the whole NHS at risk.[13] Coping with the genuinely increased clinical and social pressures on the NHS has become intolerable in this context.

We should remember the overwhelming importance, *for all citizens*, of an excellent NHS. For those who can afford private medicine and want to make use of it, there can be benefits. However, most people cannot afford it, and those who can ultimately rely on the NHS if things go seriously wrong.

We should also remember that the large majority of doctors, nurses and other staff in the NHS have a streak of idealism in them – they are there because they want to heal the sick. They would otherwise earn their living in a much less personally and physically demanding way.

And politicians should remember that raising taxes to increase spending on the NHS, important though it might be, is a relatively easy option. It misses the major point, and ignores the more difficult challenges.

This paper is written in the optimistic belief that things can be different. It foresees a modern NHS entering its second 70 years free from the accretions of its first 70 years, but better for the sometimes painful lessons it has learnt.

## CORE PROBLEMS.

### The absence of a clinically informed national management structure.

Let us look at the NHS in England. The Chief Executive of NHS England is a career manager, and only 4 of the 17 members of the NHS England Board have a medical or nursing background. However able and admirable are the individuals concerned, the top tier of the NHS is not structured to provide informed and authoritative scrutiny of government policy initiatives, nor to contribute effectively to the leadership and continued improvement of the NHS.

The Department of Health stands to one side, with its numerous components all directly responsible to politicians.

The primary flow of authority and responsibility is from politicians and civil servants at the Department of Health, with little substantive clinical input.

### Politics and the NHS.

Government influence on and control of the NHS is necessary. As the holder of the purse strings, the government has ultimate control. But, if it is ever to have stability, the NHS must operate at arm's length from politicians.

If patients wait too long for a GP appointment, in spite of GPs working absurdly long hours, politicians feel they need to step in with a quick fix.[e.g.14] Dr Laurence Buckman, Chairman of the BMA General Practitioners Committee at the time, stated in June 2013 that **"**Ministers must stop announcing things without thinking, and work for real solutions with those who know how to deliver healthcare**"**.[15] He was absolutely right.

Government policies can sometimes have devastating effects. Two political initiatives, described by politicians themselves as "historic mistakes", were alluded to in the Introduction.[10,11] We might well have witnessed a third historic mistake on the 27th February: the Government made the politically popular announcement that it would devolve £6 billion in health and social care spending to Greater Manchester.[16] Devolution of spending is a good idea. Hospital Chief Executives and Chairpersons of GP Boards (see later) should have a large measure of discretion on how their budgets are spent on hospital services and on all primary medical, nursing and social care. However, the devolution of spending on this colossal scale

to Greater Manchester, and presumably in the future to other regional Councils of widely diverse political persuasions, risks waste of resources, fragmentation of the NHS, and a post-code lottery for services.

We might be on the verge of a fourth politically popular historic mistake - the seven day NHS.[17] This was a rapid response from the Government to alarming figures that death rates were 11% and 18% higher for patients admitted to hospitals on Saturdays and Sundays respectively in comparison to Wednesdays.[18] David Cameron has described these figures as shameful, *which potentially they are*, and it is now Government policy to have "a truly seven day NHS" in place by 2020.[17] The government has never been clear on what it means by a truly 7 day NHS,[19] but the the plan presumably is to solve the apparent problem of higher mortality for weekend admissions by making Saturdays and Sundays as much as possible like Wednesdays.

### *The seven day NHS - a current example of disjointed management.*

The seven day NHS was announced without consulting medical or nursing organisations. It has been strongly resisted by the BMA and by many doctors and nurses, and has resulted in slanging matches with the government, in particular involving Jeremy Hunt and NHS Consultants. This is because the 2003 Consultant contract does not require Consultants to do *non-emergency* work out of normal hours, something that a truly seven day NHS requires. The 2003 contract does, however, require Consultants to provide care 24 hours per day, 7 days per week, which Consultants have always done. It could not be otherwise, as hospitals are always full of sick patients, quite apart from new admissions. An online petition calling for Jeremy Hunt's resignation has attracted in excess of 200,000 signatures.[20]

This is a destructive argument that should never have happened in the first place. It would not have happened had the NHS structures proposed in this article been in place.

The original study was for deaths over the 2009/2010 financial year. The authors have repeated the study for deaths over 2013/2014, with broadly similar results,[21] so there can be no doubt as to the validity and the importance of the statistics. However, mortality figures of this kind can be influenced by many factors both inside and outside hospitals. For example, the authors note that patients admitted on Saturdays and Sundays are more seriously ill than those admitted on Wednesdays, although this does not appear to explain the increased mortality.[21] The figures have generated a great deal of discussion in the medical literature.[e.g. 22] As the authors of these studies have themselves noted "It is not possible to ascertain the extent to which these excess deaths may be preventable; to assume that they are avoidable would be rash and misleading".[21]

A truly 7 day NHS in the hospital service (even if it were achievable without serious disruption of weekday services) could turn out be an expensive luxury, to a large extent irrelevant to the mortality figures that precipitated it.

The statistics do demand careful consideration, ideally jointly by the Government, the BMA and the Royal Colleges. In particular, there needs to be an evaluation of the quality of out-of-normal-hours care in NHS hospitals, with regard both to the level and seniority of staffing and the availability of support services. [For a more detailed consideration of out-of-normal-hours care in hospitals, please refer to Addendum 1].

Let us look at the Government's plans for a seven day NHS in general practice. Until 2004, when GPs gave up their contractual obligation for out-of-hours care, general practice was a genuine 7 day NHS service, or 24/7 as it is currently described. The seven day NHS current-

ly proposed for general practice is in fact a 12/7 service, not a 24/7 service. It is from 8 am to 8 pm, 7 days per week. So if patients want a non-urgent consultation with their GP on Saturday afternoons or Sunday mornings, that will be fine. But if they are concerned about themselves or their children at 10 pm in the evening or at 3 am at night on any day of the week or at weekends, they will have to fall back on the current, suboptimal out-of-hours care (see later).

### The culture pervading the NHS.

An insidious problem is the culture that now pervades the NHS. The culture is drifting away from an unwavering expectation of personal excellence and the assumption of personal responsibility. It is relying increasingly on the external imposition of externally set standards, with Inspectors assessing easily measurable criteria. If the quality of care is found to be poor, the usual response is to appoint more Inspectors and to increase the frequency and the complexity of inspections.

## THE CURRENT SITUATION.

### The hospital service.

Teaching hospitals and District General Hospitals are large, hugely complex organisations, and running them well is probably more demanding than running a large international business. It requires a high level of leadership, specialist knowledge and excellent management ability.

It is impossible to have a definitive assessment of leadership quality in each of the several hundred NHS hospitals in England. Some are undoubtedly excellent. However, there can be little doubt that the calibre of leadership overall is poor.

The average tenure of Chief Executives of NHS hospitals is slightly less than 2 years,[23] which suggests a system where incumbents play a transient management role, rather than one of leadership and ambitious planning for excellence. Morale is low and falling among doctors, nurses and other hospital staff.[3-5] Responsibility for decision-making seems too frequently to be outsourced to private Management Consultancies, which is a sign of weak leadership, and hugely costly to the NHS. In spite of Government pledges to “slash” spending in this area, it increased from £313 million in 2010 to £640 million in 2014.[24] Vast sums (£2.6 billion in 2013/2014) are being spent on agency staff,[25] which is a consequence of poor planning at national level, and a tendency to short term solutions. Behaviours which are absolutely unacceptable are exposed from time-to-time, for example requiring ambulances with their sick patients to wait outside hospital boundaries, so that waiting times in Accident and Emergency Departments can be kept artificially low.[26] When crises occur, the response of Chief Executives is usually inadequate or non-existent. If hospitals were businesses, many Chief Executives would long since have departed.

NHS Hospitals are burdened by serious underfunding, including large historical debts. Around 90% of hospital Trusts are heading for a financial deficits this year,[27,28] which complicates management. Commissioning and privatisation are also creating difficulties and uncertainties. However, poor quality leadership by Chief Executives is almost certainly the most important problem currently facing the NHS hospital service, both at individual hospital level and at national level.

A fundamental reappraisal is required regarding the sort of person who should be considered for the hugely important and hugely difficult post of Chief Executive of an NHS hospital.

## General practice.

General practice is being driven by unrestrained market forces and political pressures into an industrialised service with an impossibly high workload and an unsatisfactory organisational structure. As a consequence, 34% of GPs are considering retiring in the next 5 years.[29] More worryingly, young doctors are turning away from general practice as a career choice, even though general practice is overall better paid than hospital medicine. Over 2013 to 2015, the number of young doctors applying for GP training posts fell by ~15%.[30] In 2013, 2,764 GP training posts were filled in England. In 2014, the number fell to to 2,564, with almost 300 available training places left unfilled.[31] This is in spite of special efforts to fill them, and a government target of 3,000 GP trainees per annum in order to bolster the GP workforce. The downward trend continues this year.[32]

### *General practice as the focus for integrating health and social care.*

An important ambition for the future NHS is the integration of primary health and social care. This is widely seen as making a major contribution to the fabric of UK society, as well as improving patient care and the efficiency of the NHS.[33] General practice must play a central role in this development. However, this ideal is being made more difficult by the intervention of private healthcare companies, the encouragement of diverse local models of health care delivery and the rise of large, autonomous primary care NHS Trusts providing district nursing, physiotherapy, dietetics, speech therapy and so on. An example of a Primary Care Trust is Kent Community Health NHS Foundation Trust. It has the usual cohort of Chief Executive, Executive and Non-Executive Directors, and so on, and it serves a population of ~2 million people, employs 5,500 staff and has a budget of ~£237 million.[34] It is one of 25 Health and Care Trusts in England, five of which are Foundation Trusts. These Trusts are a hindrance to the devolution of primary medical, nursing and social care to GPs via Regional GP Boards (see later).

### *Out of hours emergency cover.*

Prior to 2004, GPs had a contractual obligation to provide out-of-hours (i.e. nights and weekends) emergency cover for their patients. By 2004, out-of-hours care in general practice had evolved into a system of GP cooperatives, where several contiguous practices shared an on-call rota. Many felt that these cooperatives provided a good balance between the personal demands made on GPs and the provision of high quality emergency cover for their patients. In 2004, the Labour government offered GPs the opportunity to give up out-of-hours responsibility with marginal loss of income. The large majority of GPs accepted, which is understandable. However, this provided an opportunity for private companies to step in to fill the gap. Whereas previously out-of-hours emergencies had always been handled by trained local GPs, the companies sometimes used foreign doctors, or substituted nursing staff or paramedics for doctor contact.[35] The objective of course was to maximise profits. Financial pressures sometimes resulted in dangerous levels of out-of-hours doctor cover.[36] The predictable consequence was a decline in the quality of emergency cover, followed by decreased public confidence in the system. It is well beyond reasonable doubt that this was a major factor causing the unplanned rise in the use of hospital Accident and Emergency Departments.[37]

The Conservative government, against strong medical advice,[38] established the telephone consultation service NHS 111 in a futile attempt to deflect patients from Accident and Emergency Departments. One of the problems with NHS 111 is that call handlers (for reasons of cost) do not need to have any clinical training - qualifications required are only GCSEs. Clinically inexperienced call handlers, understandably, refer patients to the ambulance service and to Accident and Emergency Departments more frequently than GPs. Matters are getting

worse: the number of patients referred by NHS 111 to Accident and Emergency departments rose from ~375,000 in 2013 to ~1,100,000 in 2014.[39]

Dr Chaand Nagpaul, the Chair of the BMA General Practitioners Committee, commented in July 2013 that "NHS 111 has been an abject failure".[40]

*The structure of individual practices.*

GPs (unlike hospital doctors) are independent contractors to the NHS. GP practices are in essence small businesses which have only one customer – the NHS. This was a concession made by Aneurin Bevan to the general practitioners of the day, to ensure their support for the NHS at its formation. Interestingly, this model has worked very well, mainly because it gives GPs freedom from centralised control while simultaneously allowing the NHS, as the only customer, to influence (but not dictate) how general practice functions. An incidental advantage is that it avoids a large and expensive bureaucracy to oversee ~37,000 GPs scattered in ~8,000 practices in England.

Traditionally, every GP was a partner in a practice, participating in the running of the practice, contributing to out-of-hours cover at night and weekends, and taking a share of the practice profits. The removal of out-of-hours responsibility in 2004 meant that there were few practical problems, and major financial advantages, with reducing the number of partners in a practice. By replacing partners who retire with salaried doctors (on salaries less than a partner's profit share), the income of the remaining partners increases. Replacing partners with salaried doctors has become a common practice. Simultaneously, as the lifestyle of partners becomes increasingly onerous and chaotic, many GPs (especially those with primary responsibility for childcare) are shunning partnerships and prefer to work as salaried doctors on fixed hours. The statistics are striking. The number of GPs in England over the 10 years from 2003 to 2013 rose by over 17%, from 30,368 to 35,561, reflecting an initiative to increase GP numbers in the UK. However, the number of partners over this period *fell* by 7%, from 28,640 in 2003 to 26,635 in 2013, while the number of salaried GPs increased by 435% from 1,712 to 9,153.[41] This has led to a two tier system of GPs: overworked partners on the one hand, and an increasing cohort of less well paid but less stressed salaried doctors on the other.

This situation has made it attractive for private companies to enter general practice: there is a more-or-less guaranteed profit to be made in taking over practices and employing salaried doctors and nurses to run them. Currently, private companies (e.g. Care UK, Virgin Care) run hundreds of general practices in England, with GPs as salaried employees. Private companies are not an ideal environment for a family doctor in the NHS, in particular on account of loss of independence.

The small business model of general practice works well while all GPs are on an equal footing. It worked well while the prevailing culture was one where young doctors entering a practice expected to become full partners, and were given full partnerships as a matter of course, usually over a 2 or 3 year period. However, unfettered by either culture or regulation, the small business model is being driven by crude market forces to a situation where most GPs will be salaried, and employed either by diverse private healthcare companies or a small rump of the more entrepreneurial GPs. This is unsatisfactory, both for GPs and for general practice.

### *Workload.*

Workload is currently the most important single issue facing general practice.[42,43] In spite of a substantial increase in the number of GPs in England over the past decade, and the fact that the majority of GPs work absurdly long hours, GPs are finding it increasingly difficult to deliver their core function – to see patients coming to them with health problems.

GPs (like hospital Accident and Emergency Department staff) occupy a special position in the health service - they are on the front line of medical care. If there are 100 patients to be seen, they all need to be seen in good time, because among them are likely to be some patients for whom delays are harmful. It is vital to bear this in mind when considering how to deal with this problem.

GPs are not employed by the NHS, as mentioned above, and so the European Working Time Directive does not apply. Consequently, there is no upper limit to the hours they can work.[44] The spouse of the author is a GP partner, and a typical day for her starts at 8-15 am in the surgery (7-20 am on 1 in 4 days) and she leaves the surgery at ~8-30 pm, sometimes later, after 12 or 13 hours of unrelenting work, without breaks. Reviewing patients' pathology results and letters from Consultants, and so on, and contacting patients when necessary, are mostly done from home, usually at weekends. If there are nursing homes to visit, she usually does this on a day off or on Saturday.

[For further details on GP workload, please refer to Addendum 2].

## PROPOSALS FOR THE FUTURE.

These proposals are for the NHS in England, but they apply equally well for the other UK regions.

A central tenet of this paper is that a successful NHS is achievable only via a partnership between politicians and clinicians. The proposals begin by suggesting a viable and credible clinical arm to such a partnership, in the form of a reconstituted, clinically strong and democratically legitimate NHS England Board.

### A stronger national clinical structure for the NHS.

The Executive Directors of the NHS England Board should be expanded to include a majority of senior representatives from the medical and nursing professions, put forward by the eleven medical Royal Colleges and the Royal College of Nursing, and including representatives from Chief Executives of NHS hospitals and Regional GP Boards (see later). The medical Royal Colleges vary hugely in size, but a critical issue is representation of diverse expertise. In these proposals, the eleven medical Royal Colleges would put forward one nominee each, and the Royal College of Nursing two nominees. It might be wise to exclude current members of College Councils from nomination, in order to encourage Councils to engage in a College-wide search for the most appropriate individuals for these hugely important positions. The individuals nominated would be chosen for their knowledge, integrity and leadership qualities. The nominees would be from the Royal College of Physicians, Royal College of Surgeons, Royal College of General Practitioners, Royal College of Paediatrics and Child Health, Royal College of Obstetricians and Gynaecologists, Royal College of Psychiatrists, Royal College of Pathologists, Royal College of of Emergency Medicine, Royal College of Ophthalmologists, Royal College of Anaesthetists, and Royal College of Radiologists. The Royal College of Physicians should make a second nomination to cover the Faculties of Public Health, Pharmaceutical Medicine and Occupational Health, all of which originated from the College of Physicians.

A crucially important link from the NHS England Board to GPs would be provided by including two individuals nominated from Third Tier GP Boards (see later) and an equally important link to hospital doctors would be provided by including two senior Chief Executives from Second Tier Chief Executive Boards (see later).

All eighteen of these additional Board members should ideally be practising clinicians. Board membership is unlikely to require more than perhaps one day per week, at least once the NHS has stabilised, so membership of the Board should not be a professional problem for those chosen. It should be for a fixed term, say three or four years renewable once. These positions, because of their interest and importance, are likely to be attractive to senior doctors and nurses.

The reconstituted Board of NHS England would be broadly based clinically at a senior level and have substantial democratic legitimacy, and consequently would carry considerable clinical and political weight. It would establish a clear line of responsibility from the Board of NHS England to doctors and nurses at the coal face, and would provide the government with a clinically informed and authoritative advisory board.

All that is required for this proposal to be put into effect is a consensus that it should happen.

### General organisational matters.

*General practice and primary care would be managed separately from hospitals.*

GPs need to refer their patients to hospitals offering excellent specialist services. Hospitals, once they have completed their treatment, need to return their patients to the care of the referring GPs. Simon Stevens speaks of “breaking out of the artificial boundaries between hospitals and primary care”. He wants to “break down barriers”. Many do not see the barriers that exist in Mr Stevens’ vision.[12] The only meaningful barriers are operational ones: when GPs want to refer their patients to hospitals for specialist services, and these specialist services are inadequate and under-funded, or when hospitals are unable to return patients into primary care because of a lack of nursing facilities or social support in the community.

*The internal market and commissioning (including Clinical Commissioning Groups) would be abolished.*

The commissioning of services, whether internally in the NHS or with private healthcare companies, creates a pseudomarket with an expensive bureaucracy. It is wasteful of doctor time and achieves nothing of substance. It can have a negative influence by creating uncertainty and destabilising NHS services, especially when commissioning involves private healthcare companies and long-term contracts.

Contrary to the beliefs of some administrators, services do not have to be commissioned. They can simply be funded on a nationally agreed basis, and organised within an existing framework, e.g. district nursing by Regional GP Boards (see later), hospital services by high calibre Chief Executives. Appropriate incentives for quality can be incorporated into such a structure. [For comments on funding the hospital service, please refer to Addendum 3].

CCGs would be replaced by Regional GP Boards (see later). These would focus entirely on primary medical, nursing and social care.

*Private provision of clinical and domestic services in hospitals would be minimised.*

Chief Executives would be given the objective of achieving high quality NHS clinical services throughout their hospitals. Outsourcing hospital clinical services should be seen as a tempo-

rary measure, and used only when it is essential to maintain provision of a high quality service. In many cases, it represents an easy option for weak management.

Chief Executives would also have the responsibility of ensuring high quality in-house domestic services. Domestic services play a crucial role in all hospitals, not only for the general welfare of patients, but also for clinical issues such as infection control. In-house domestic services under good leadership offer the best chance of high quality provision.

### *Does one size fit all?*

One of the pervasive mantras is that one size does not fit all.[12] This simplistic notion has the same value as the superficially startling fact that nobody has two ears of identical size. It has provided a rationale for encouraging local groupings all over the NHS to organise themselves in a way that suits them best in order to meet local needs. However, local variations in health care delivery will almost certainly have more to do with the abilities, political persuasions and personalities of the individuals making the decisions, and with the nature of the interested private companies operating in the area, than with any substantive local variation in medical or social needs. It will make national coordination and prioritisation of services more difficult.

The medical and social needs within the various parts of England are sufficiently similar to be accommodated within the same core organisational structure. Where there are substantive local differences in need (e.g. in inner city deprived areas), these can be accommodated by the devolution of responsibility to Regional GP Boards and hospital Chief Executives, operating within a supportive national structure.

### **Leadership of NHS hospitals would usually be devolved to Clinical Chief Executives**. *The advantages of a clinical background.*

It is very unusual in the business sector for the Chief Executive of a large company not to have a background in that company's business. By contrast, it is rare for an NHS Chief Executive to have a clinical background.

Doctors and nurses have specialist knowledge and an understanding of the clinical environment - a major advantage for the effective management of complex health services. Their work and their training brings them into direct contact with patients, and gives them an important perspective.

The government has trumpeted the idea that the recent reforms have already put the NHS in the hands of doctors and nurses. In fact, a minority of GPs has been given responsibility for most of the NHS England budget, especially to purchase hospital services. This is of peripheral interest to most GPs, and disenfranchises and destabilises hospital doctors.

### *Clinical Chief Executives.*

The appointment of a high calibre Chief Executive in each of the several hundred teaching and District General Hospitals in the NHS is central to a successful future for the hospital service and for the NHS as a whole. However, high calibre Chief Executives are unlikely to be attracted in any significant numbers from the business sector. How then can we proceed?

NHS Consultants are able people with a personal interest in the quality and reputation of their hospital, and they have the advantage of a clinical background. A small minority of the UK's ~45,000 NHS Consultants will have the appropriate personal qualities to be successful Chief Executives. In these proposals, it is envisaged that each DGH and teaching hospital

would have a medically qualified Chief Executive, ideally an NHS Consultant, and usually (but by no means invariably) from the hospital where the appointment is made.

There is strong support among the public for a greater role for doctors in managing the NHS, [45] but doctors are reluctant to take on these roles. They do not want to give up their clinical work, and they see management as a one-way ticket into an uncertain and unrewarding career.[46] A key point of these proposals is that the Clinical Chief Executive role would be for set periods, say 4 years renewable once, and that most (but not necessarily all) doctors undertaking this role would retain some clinical work during their management period. It is anticipated that most would return to full-time clinical work at the end of the Chief Executive appointment. Clinical Chief Executives of large teaching hospitals would probably need to contribute 4 days per week to the role of Chief Executive, retaining one day per week for clinical work.

Will Consultants be interested and willing to take on this responsibility? Will the right ones put themselves forward? If Clinical Chief Executives were given full responsibility for and discretion over all clinical and non-clinical services at their hospital, it is likely to be seen by Consultants as an interesting and potentially hugely rewarding challenge. Moreover, in the new NHS, Clinical Chief Executives would not be acting in isolation, but as part of a national structure of Clinical Chief Executives (see next section).

The appointment system for Clinical Chief Executive should ensure that the individuals appointed have the support of the medical and nursing staff at their hospital. For example, although the post of Clinical Chief Executive at any particular hospital should be open to all UK Consultants (and perhaps more broadly to all doctors on the GMC Register), the selection process should include a ballot of senior doctors and nurses at the hospital to select one local Consultant or Honorary Consultant to be put forward as a local candidate. It is in the interests of all staff to encourage the appropriate Consultants at their hospital to put themselves forward.

It is important that financial considerations *not* be a major motivating factor for Consultants to take on this role. Clinical Chief Executives should therefore continue to be paid on normal NHS Consultant scales, with no bonuses and no redundancy payments related to the Chief Executive role. However, Clinical Chief Executives would be eligible for payments available to all Consultants for outstanding contributions to the NHS, both during and at the end of their Chief Executive role. These additional payments are usually maintained to retirement, and so would represent a substantive financial remuneration if the role of Chief Executive was performed well.

This proposal need not (and in practice could not) be taken up simultaneously by all hospitals. Each hospital would make its own decision independently of others, depending on the wishes of the senior clinical staff, the quality the existing leadership and the turnover of Chief Executives. If the idea proves popular, and given the current high turnover of Chief Executives, the majority of NHS hospitals could have Clinical Chief Executives within 2 years. By that time, the success of this proposal in terms of quality of leadership (including the all important re-engagement of clinical and other NHS staff with their hospitals) will be clear.

If Consultants do not take on this role, it is difficult to see how this core problem in the NHS will be resolved.

[For comments on management structure under Clinical Chief Executives, please refer to Addendum 4].

*Regional Boards of Chief Executives - a national structure for the hospital service.*

After a period of perhaps one year, by which time a significant number of Chief Executives are likely to be Consultants, the Chief Executives of around 10-15 hospitals serving contiguous areas would formally come together as a nationally recognised First Tier Chief Executive Board - which would meet periodically, say every 3 or 6 months. Each First Tier Board would elect a chairperson, and the chairpersons of the First Tier Boards would form the Second Tier Chief Executive Board. This Board would be representative of all NHS hospitals in England. It would meet periodically, and when required to do so would nominate two Chief Executives (preferably clinical) to the Board of NHS England.

This Board structure would provide an ideal forum for the identification and resolution of important national problems within the hospital service. One important example is the disorientation and physical and mental collapse suffered by patients with dementia when they require an inpatient stay, as recently described so poignantly by the Observer columnist, Nicci Gerrard.[47] As she rightly pointed out, her father's horrific experiences were not the fault of the hospital staff. It is a common and hugely distressing problem, most especially for the bewildered patients themselves and for their families. Nobody quite knows how to deal with it. Interestingly, following Nicci Gerrard's article, an initiative led by patient's families has made an important contribution: many hospitals are now allowing a relative or carer (if one is available) to stay in hospital with the patients.[48] It is somewhat shameful that this simple but important initiative came from the public rather than the NHS. However, if a national Board of Chief Executives were in place now, it could ensure the rapid dissemination of this idea, and it would be in an excellent position to secure any necessary national funding to facilitate and optimise implementation. This Board could investigate further advances in the inpatient care of patients with dementia, in a nationally coordinated manner with earmarked funding if necessary.

## General practice.

General practice cannot go on much longer in its current state and on its current trajectory.[42,43,44,49] And yet there is no credible solution on offer for this complex and difficult issue, even though general practice is at the core of the NHS.

Labour has suggested that general practice should be run by hospital Trusts (Integrated Care Organisations, or ICOs). Dr Maureen Baker, the Chairperson of the Royal College of General Practitioners, commented as follows: "His (Andy Burnham's) plans could destroy everything that is great and that our patients value about general practice, and could lead to the demise of family doctoring as we know it".[50] Hospitals have been described as having a "huge appetite" for primary care takeover,[51] perhaps seeing general practices as an additional source of income and also as a way to help relieve pressure on their Accident and Emergency Departments.

Simon Stevens[12] has suggested Multi-Specialty Community Providers (MCPs), where large federations of general practices provide specialist services in the community, including the employment of Consultants. Who will run these MCPs and which of the many specialist services will individual MCPs choose to offer? Which individual doctors or private companies will retain the profits from running MCPs? Local mushrooming of diverse MCPs will fragment the hospital service in a way that is difficult to predict. MCPs will be more convenient for patients, but it is questionable if the quality of specialist advice available will compare favourably with that on offer in hospital specialist departments, where numerous Consultants with particular skills and interests work together. It is certainly not clear that MCPs will be cheaper than referring patients to hospital departments.[52]

The core function of general practice must be to provide patients with a high quality, skilled and sympathetic first interaction with the NHS for both diagnosis and therapy, and a professional guide into the hospital service when that is assessed to be necessary. General practice is also the natural focus for the integration of social care and clinical care, which is an urgent national priority both for patients and the NHS. And general practice is also the most effective base for the implementation of public health measures, which have huge potential for disease prevention. Turning general practices into mini-hospitals of one sort or another distracts and detracts from these fundamental objectives.

*General practice and all primary care would be devolved to Regional GP Boards.*
All primary medical, nursing and social care would be the responsibility of Regional GP Boards, using the boundaries of the 211 existing CCGs (thereby making use of the substantial demographic data already collected for CCGs). However, Regional GP Boards would have different perspectives and objectives. They would liaise closely with hospitals, but focus entirely on primary care. Regional GP Boards would typically cover ~200,000 to 250,000 patients and have ~30 to 35 general practices, and sometimes 1 or 2 community hospitals within their area of responsibility. Regional Boards would be simpler in structure than CCGs, and less expensive to run.

GP Boards would each consist of around 10 GPs, all drawn from partners in the practices in the Board area, with no practice contributing more than one Board member. Salaried doctors would not be eligible to stand. Membership of the GP Board could be by an election organised by the Department of Health, with all GP partners based in the Board area eligible to stand and to vote. Membership would be for 4 years, renewable once.

Patient participation groups (PPGs)[53] have become a valuable part of general practice, and most practices nowadays have an active group. All practices within a Regional Board would be encouraged to have a PPG. The chairpersons of the ~30 or 35 PPGs within a Board should meet periodically, and they would elect one of their number to join the Board. The PPG member would serve as a lay member of the Board for a fixed term of say 1 year, renewable once by mutual consent.

The members of the Board would elect a Chairperson from among themselves. The Board would also appoint a senior nurse working in the Board area to membership of the Board. The nurse member's tenure would be for 4 years renewable once, as for the GP members.

Members of the Board would usually devote one day per week to Board duties.

All funding of individual GP practices (capitation fees, QOF targets, etc.) in the Board area would continue to be the responsibility of the Department of Health. However, the GP Board would control the budgets for all primary medical services (such as physiotherapy), nursing services (such as district nursing) and relevant social services (such as home help) in their area. This would require meetings of the chairpersons of several Regional GP Boards (perhaps a second tier Board, see below) with local Primary Care Trusts and local Councils, under the chairmanship of the Department of Health, in order to decide how best to devolve responsibility, budgets and staff for each area of primary care to Regional GP Boards.

The Chairperson would be primarily responsible for oversight of the Regional Board and with issues at supra-Regional Board level, such as liaising with the Department of Health, local hospitals and local Councils, and participation in the Second Tier GP Board (see below). Each of the other nine GPs would be responsible for a particular area of primary care. For example, one GP (together with the nurse member of the Board) could be responsible for

nursing homes and district nursing, one GP for preventive medicine, one GP for coordinating general practice with mental health services, one GP for social care, and so on. Ideally, the areas of responsibility would be the same in all Regional GP Boards in England, in order to facilitate regional and national coordination in these key areas. The Board would have regular formal meetings, perhaps once every 2 weeks.

Will GPs be interested in participating in this structure? Will the right GPs put themselves forward? Membership of GP Boards offers substantial responsibility, and a real opportunity to greatly improve local primary medical, nursing and social services. It also offers the opportunity to contribute to important improvements in primary care at a national level. GPs are likely to find this an interesting and rewarding challenge. GPs in every Board area should encourage those best suited among them to stand for these positions - it is in everybody's interest that they do so.

Remuneration of GP Board members, including the chairperson, should be generous but not excessive, and should take particular care to distinguish between personal remuneration of the Board member and the reimbursement of practices for GP locums to cover the GPs' absence on Board duties. Currently, the chairperson of a CCG can earn ~£85,000 - £90,000 per annum for a nominal two days per week on Board duties while at the same time retaining a substantial (e.g. three quarter time) partnership in general practice. By way of comparison, the pay for a full-time NHS hospital Consultant, after 13 years experience as a Consultant, is £90,000 per annum.

[For further comments on the funding of Regional GP Boards, please refer to Addendum 5; and for a note on funding general practice, please refer to Addendum 6.]

The costs of CCGs currently average ~£5-6 million each per annum, with the total running costs for the 211 CCGs in England in 2013/2014 being £1.35 billion. It is likely that the annual running costs of Regional GP Boards will be significantly lower than for CCGs.

### *Tiered Regional Boards - a national structure for general practice.*

The chairpersons of 10 contiguous GP Boards would form a Second Tier GP Board, which should meet periodically. There will be ~20 of these Second Tier GP Boards, and each should elect a chairperson. These ~20 chairpersons will collectively represent all of general practice and primary care services in England, and will form the Tertiary GP Board. The Tertiary GP Board would elect two of its members to the Board of NHS England when vacancies arose.

The Tertiary GP Board would be ideally placed to tackle important national problems in primary care, e.g. the burden of cost of nursing home care, and the low level of provision of nursing homes. There could be a vision of high quality NHS Nursing Homes run by senior NHS nurses, if NHS funding permitted or if prioritised funds were made available nationally.

The chairpersons of Regional GP Boards would be key points of devolved responsibility and decision taking in primary care in the NHS. They would be able to work in a coordinated manner within the above national structure.

### *The GP workforce.*

Workload per GP has increased in spite of the fact that the number of GPs in England has been increasing for many years. For example, over the 10 years from 2002 to 2012, the number of full-time equivalent GPs in England increased by ~6,700 (23%) to nearly 36,000. This increase in GPs is on a background of a much higher (54%) increase in full-time equiv-

alent hospital Consultants over 2002 to 2012, to ~38,200.[54] It is possible that some of this large increase in Consultants has been needed to accommodate the current Consultant contract, based on 10 units of programmed activities (40 hours per week), in place of the much longer hours worked by most Consultants before 2000. In any case, the number of doctors per 1,000 of population in the UK (2.71) remains substantially lower in comparison with our comparable European neighbours, e.g. France (3.27), Germany (3.73), Spain (3.78) and Italy (3.92).[55]

Training a GP takes 5 years from the time of graduation from medical school. It involves 2 years of general hospital training undertaken by all doctors, followed by 3 years of training for general practice. There is therefore a lead time of at least 3 years before increasing training posts in general practice results in more GPs actually in practice. And it assumes that young doctors actually choose general practice over hospital medicine as their career choice.

It is widely accepted that GP numbers must expand urgently to meet increasing demands. The Government is aiming to increase the number of GP trainees to 3,250 per annum (half of all trainees) from 2016, from the 2,564 GP training posts taken up in 2014.[30] If this can be achieved, projections are that the number of GPs in England will increase by ~3,000 or 4,000 by 2018, with additional increases accumulating thereafter. However, these predictions are tentative because of uncertainties regarding how many GPs will retire in the next few years, and the continuing difficulties of filling GP training posts, even when they are made available, as discussed above.[29-32]

Steps are also being taken to retain existing GPs, and to facilitate the return of GPs into the workforce (e.g. after a period abroad).[56]

How GP numbers will develop in the coming years is uncertain. The best thing that can be done to retain existing GPs and to encourage young doctors to become GPs is to make general practice once again a personally satisfying career with a demanding but sensible lifestyle.

More effective deployment of recently qualified GPs could make a difference. It can be implemented relatively quickly, and might help to restore a more positive and optimistic culture within general practice (see later).

*Funding model would be via the current small business model, but regulated.*

The unregulated small business model is currently driving general practice towards a salaried service, with GPs in the employ of various private healthcare companies and a progressively smaller number of entrepreneurial GP partners, as discussed above.

An alternative is a salaried GP service, with the NHS as the employer. That would result in a more bureaucratic system (both for the NHS and GPs) with less independence for GPs. It is important to note that if salaried NHS GPs agreed to work only a 40 hour week, including administration time, the service would collapse. Even if GPs agreed to work a 48 hour per week (the upper limit allowed by the European Working Time Directive, which has applied to hospital doctors since 2009), this would cause major problems. The option of a salaried NHS service is likely to remain unpopular with GPs, unless working conditions continue to deteriorate.

Another possibility is for GPs simply to opt out of the NHS altogether, which would be disastrous for the NHS. Private GP services are currently a negligible component of general practice. However, it could become more popular with GPs, and with patients who can afford it.

The best funding model is the current “small business” model, but with the introduction of a crucial regulation at the end of a transition phase of 3-4 years (see next section).

### A *transition phase of 3-4 years to stabilise general practice.*

A transition phase of 3 or 4 years is required to stabilise general practice. There are unfortunately no quick fixes to the current problems.

Prioritisation of the demands made on general practice could make a small but significant difference (see next section). However, the main objective during this transition phase would be to share the workload among a larger number of GPs. The practical problem is that simply releasing several thousand additional GPs (assuming they were available) into the current small business model is not an effective approach. Many overworked practices will not take on an additional GP, for the simple reason that this would lead to a substantial loss of income for the existing partners. Attempting to balance the system financially for increased GP numbers by making additional funds available for GP income (e.g. via increased capitation fees), would also not solve the problem - most of the additional funds would be absorbed by current GPs.

The way general practice is funded within the small business model needs careful consideration. Over this transition phase, funding should be geared to achieve 5 key objectives:

- Reduce workload per GP to sensible levels.
- Maintain average GP incomes at approximately current levels.
- Encourage an increase in GP numbers.
- Maintain clinical standards.
- stabilise the small business model beyond the transition period.

If the GP workforce is to expand without loss of income to existing GPs, additional funds for GP income must be provided. How to deploy these funds effectively within the small business model is the key practical issue. Probably the only way to achieve this is to provide central funding for several thousand recently qualified GPs during the transition period, and at the end of the transition period to regulate the small business model by placing an upper limit on fundable patients per partner in a practice.

In these proposals, ~4,000 *centrally funded* young GPs would be deployed by the 211 Regional GP Boards into practices throughout England, *at no cost to the practices.* Once the GP Boards are in place, say during 2016, each Board would be given an average of 10 GP posts (depending on the number of patients within the Board) to distribute among the practices within the Board during 2016. This exercise would be repeated in 2017. These posts could be used as required both by the practices and the young GPs applying for the posts. For example, 10 posts could be used as 6 full-time, 2 three quarter time and 5 half-time posts. This amounts to an average of a half time GP for each practice in England. However, one partner practices could be excluded (because they are not an ideal environment for general practice) and larger practices could be limited to one centrally funded GP, and so the

majority of practices (3 to 5 partners) would receive one full time new doctor. This will make an appreciable difference.

If this exercise was successful but additional GPs were still needed (and provided that more young doctors had become encouraged to train as GPs in the meantime), the transition phase could be extended by one or two years and another 2,000 centrally funded GPs could be deployed over 2018/2019.

It would be a requirement that centrally funded GPs are given a contract by the recipient practice on joining the practice such that, at the end of the centrally funded phase, the new GP would continue in the practice as a profit-sharing partner (half, three quarter or full time as appropriate). It would also be a requirement that these centrally funded posts would be open only to young GPs, say within 3 or 4 years of completion of GP training programmes (adjusted for parental leave, if appropriate) in order to create attractive employment opportunities for newly trained GPs.

At the end of the transition phase, central funding for the new posts would cease, and the money used for these centrally funded posts would be redistributed to global GP funding (e.g. by increasing the capitation fee). *Simultaneously, and crucially, market forces would be regulated by setting an upper limit to the number of fundable patients per GP partner in a practice,* to perhaps 2,000 or 2,200. This upper limit would have to be carefully considered and agreed nationally. It would encourage practices to become partner-based and sensibly staffed during the transition phase, and would prevent a return to the current situation.

The agreed upper limit of fundable patients per partner must leave room for better practices with GPs willing to work harder than average to have higher than average list sizes. It should also leave some room for salaried doctors. For example, with a 2,000 upper limit per partner, a practice with a list size of 8,000 patients could function with 4 partners working harder than average, or 4 partners and a salaried doctor, each with a list size of 1,600 (the average list size in England is 1,600).[57]

[For further details, including fairness in allocation of posts and important safeguards against misuse, please refer to Addendum 7.]

This scheme for 4,000 additional GPs in the transition period (based on salary costs of £75,000 p.a. in year 1, £80,000 p.a. in year 2 and £85,000 p.a. in year 3) would be ~£0.15 billion in year 1, ~£0.31 billion in year 2, and ~£0.33 billion in year 3, plus superannuation and administration costs. This is feasible within the NHS budget, especially as it should be seen as a major priority.

### *Prioritisation of demands on general practice.*

An urgent initiative for the government, the BMA and the Royal College of GPs is to sit down and agree what the NHS requires of GPs. The objective of these discussions would be simple: clinical prioritisation of GP services in order to make an immediate reduction in workload without significant reduction in the quality of the service or the income of GPs. This could make a significant difference to workload, and in particular might discourage politicians from adding ever greater loads on to GPs without critical evaluation and prior discussion.

QOF targets and Enhanced services are in principle a good idea, and have improved the quality of care in general practice. However, some have been of marginal or dubious clinical value (please refer to Addendum 2), and they have contributed to increased bureaucracy. Clinically informed prioritisation to concentrate on a much smaller number of key targets

while simultaneously increasing the capitation fee is needed, and steps are already being taken in this direction.[58]

Another idea could be a national system for distributing authoritative information to patients at times of general anxiety, in order to avoid unnecessary consultations. The proposed national structure of Regional GP Boards would be ideally suited to this. Every practice would keep an up-to-date database of the email addresses of as many of their patients as possible, for one-way (no reply) communications. Patients would be free to participate or not as they chose. During influenza epidemics, or occasions such as the recent ebola crisis, the Tertiary GP Board could request that the NHS England Board organise a brief, authoritative information sheet for patients. Given the breadth of expertise in the NHS, this could be accomplished very quickly. The information sheets would be emailed by the NHS England Board to each Regional GP Board for distribution at its discretion to individual practices, and for practices in their turn to distribute at their discretion to their patients.

Another simple idea is to reduce the frequency of appraisals from annual to biennial. This would increase GP clinical time (for both appraisers and appraisees) and reduce the costs of the appraisal process, at marginal loss to its efficacy.

*Resumption of a GP-led and GP-implemented out-of-hours service.*

In the 4th year of the transition phase outlined above, i.e. after the deployment of ~4,000 - 6,000 centrally funded GPs to reduce workload, and after a careful assessment of the demands made on GPs, negotiations for a resumption of a GP-implemented out-of-hours service should be considered. Resumption would ideally be negotiated at a national level, but it could be agreed locally by individual GP Boards. Negotiations could include additional centrally funded GPs to further reduce general workload. A key issue in the negotiations would be the resources required for high quality out-of-hours care, which should be a major priority for the NHS. It is of far greater importance (for both patients and the NHS) than the seven day NHS. Quite apart from returning out-of-hours care in general practice to a high quality service, it would contribute to the stabilisation of both daytime general practice and hospital Accident and Emergency departments. If GPs were to do this, they would gain hugely in the respect of their patients and other doctors, and they would be playing a central part in rebuilding the NHS.

The Regional GP Board would be the organisational unit for the out-of hours service, and each GP Board would typically operate as a single cooperative. The cooperatives of ~2004 consisted of several contiguous practices, and on-call commitments were allocated to each practice in proportion to its list size, a perfectly fair approach. It was the responsibility of each practice to cover their allocated sessions. Of particular importance, if a GP did not want to do out-of-hours work (for example because of family commitments or if they were reaching the end of their career), it was possible by mutual agreement for another member of the same cooperative to cover their sessions (and of course be paid for them). There were usually sufficient young doctors pleased to supplement their family finances in this way. This system was flexible, not too onerous for doctors, and provided patients with excellent out-of-hours care.

A typical GP Board would have ~250,000 patients and ~150 GPs. Let us look at what would be a common scenario, a rural Board of this size covering an area of approximately 30 miles x 30 miles. Most GPs would prefer weekday evening sessions to cover 6-30 pm to 11 pm, night sessions of 11 pm to 8 am, weekend day sessions of 8 am to 6 pm, and weekend evening sessions of 6 pm to 11 pm. Weekend day sessions were sometimes divided into two (8 am to 1 pm and 1 pm to 6 pm). The highest doctor/patient ratios are usually needed dur-

ing weekend day sessions, followed by evening sessions, followed by night sessions. Because of the relatively large area covered in this rural area, this cooperative would probably need 3 GPs on duty for evening and night sessions, and 4 for weekend day sessions. The system would be operated flexibly, but essentially one or two GPs would be at a centrally located base, and would take all the calls and see the patients who travel to the base. The other GPs would do the home visits.

With the above system, GPs with an average list size would cover 1 weekday evening every 10 weeks, 1 weekday night every 10 weeks, 1 weekend evening every 25 weeks, 1 weekend night every 25 weeks and 1 weekend day every 19 weeks. This represents 1 session every 3 weeks, which is not especially onerous. As the GP workforce increases, the commitment per GP will lessen. Moreover, if the above GP Board covered an urban rather than a rural area, the number of GPs required for evening and night sessions could be reduced from 3 to 2. This would reduce the overall commitment per GP to 1 session every 4 weeks.

It would be essential to specify that, to participate in the out-of-hours rota of a cooperative, a doctor would have to be a partner or a salaried doctor in one of the participating practices.

In this system, there would be no advertising or recruitment, no vetting of applicants, and minimal administration. All doctors participating would automatically be trained GPs from local practices. If we assume ~150 hours per GP per annum at ~£60/hour, and one manager per cooperative, overall costs will be in the region of £0.35 - £0.4 billion. If a receptionist to take patients' calls and two drivers were employed for all out-of-hours sessions, this would involve a relatively modest expense, perhaps ~£60 million for the UK. However, using the above system, a receptionist might be needed only for evening and Saturday morning sessions. Drivers might not be seen as essential for all sessions in most cooperatives. However, each cooperative would probably purchase 2 cars with satellite navigation systems for use by GPs or drivers for home visits (a minor cost). The current cost of-out-of hours services is £0.4 billion, plus the cost of NHS 111.

If such a system were in place, hospital Accident and Emergency departments and the ambulance service would breathe a sigh of relief, and NHS 111 could be disbanded.

### *GP Premises.*

This is an important and complex issue that has never been satisfactorily resolved. In a recent BMA survey, 40% of GPs reported that poor quality of their premises was restricting their capacity to deliver a good service.[59] Currently, premises are usually either owned by the partners in the practice, in which case the NHS pays the practice a rental, or they are owned by a third party, usually a developer, in which case the developer leases the premises to the partners in the practice. The NHS oversees the leasing arrangements, and reimburses the practice for the annual cost of the lease. The lease needs to be for a lengthy period (often 20 years) for the project to be financially attractive to developers. Sometimes the NHS owns the premises used by GPs, e.g. rooms in a community hospital.

The £1 billion fund (£250 million per annum for 4 years) recently announced by Simon Stevens is therefore much to be welcomed.[60] It shows that NHS England recognises the problem and is prepared to commit resources on a scale sufficient to make a major difference. A point to note with Simon Steven's plan is that the £1 billion will be distributed largely as capital into premises. Where premises are GP owned, the capital immediately becomes a financial asset for the GP partners. For example, on the retirement of a partner, the partner's share of the additional funds will be translated into personal cash. This is nobody's fault and

simply a consequence of how the system operates. However, it is not ideal, and a better system would be desirable.

Because GPs are private contractors to the NHS, one could argue that GPs should be responsible for providing their own premises. This in fact appears to be the legal position, although the general perception is that the NHS is responsible for the quality of GP premises.

A system based on GP ownership of premises is probably the best way forward, with a rental paid by the NHS. In times past, one of the major banks was keen to offer GPs a 100% mortgage over 20 or 25 years at preferential interest rates in order to purchase and convert premises to GP surgeries. This was because the rentee was the NHS, and therefore the risks of the venture for the banks was low. In the system proposed here, GP partners would borrow the required funds from a bank, and there would consequently be no capital transfer from the NHS. A capitation-based rental system is proposed, which would be simple to administer and would be structured to give GPs a financial incentive to provide good quality premises.

[For further details, please refer to Addendum 8].

### Maternity services.

These involve a core hospital base and a substantial component within the community. The hospital base for maternity services is usually a component of a teaching hospital or District General Hospital, but it can be a dedicated maternity hospital adjacent to a general hospital (such as the Rosie hospital in Cambridge, adjacent to Addenbrooke's hospital).

In these proposals, the maternity service would be managed separately from the general hospital service, by a Clinical Chief Executive who is a Consultant Obstetrician. The Clinical Chief Executive would be responsible both for the hospital base and for all midwifery services in the community, and would be supported by a senior midwife serving as assistant Clinical Chief Executive for maternity services. The Clinical Chief Executive for maternity services would be a member of the main hospital's Planning and Executive committee (see Addendum 4), thereby ensuring coordination of maternity services with general hospital services.

[For additional organisational details of maternity services, please refer to Addendum 9].

Simon Stevens quotes research which "suggests" that only 25% of women want to give birth in a hospital obstetrics unit, but 85% do so.[12] He wishes to ensure that "NHS funding supports the choices women make" and will therefore "make it easier for groups of midwives to set up their own NHS-funded midwifery services". Choice, of course, is of value only if it is informed. It is for obstetricians, paediatricians and midwives, together with local GPs, to decide how best to advise the pregnant women in their care. It is not appropriate for Simon Stevens to prejudge these clinical issues on the basis of patient surveys, and then to divert substantial NHS funds in a particular direction.

[For additional notes on the delivery of maternity services, please refer to Addendum 10].

### Mental Health services.

Mental health services, like maternity services, comprise a core inpatient service and a large component in the community. The Clinical Chief Executive for mental health services would be a Consultant Psychiatrist. There would be an assistant Clinical Chief Executive post, open to Consultant psychiatrists and to nurses, psychologists and social workers working in

psychiatric care. The organisation of mental services would be as described above for maternity services.

GPs often feel insufficiently involved in the delivery of mental health care to their patients. There is a general perception that mental health services (in particular for children and adolescents) is seriously underfunded and poorly integrated into primary care.

The Regional Board structure proposed here for GPs will facilitate better integration of general practice with mental health services. Every Regional GP Board will have a GP with designated responsibility for mental health services. The tiered Board structure from local to national level, both for GPs and for Clinical Chief Executives for mental health services, will facilitate national planning and prioritisation of mental health services within the NHS.

The current trend is to give responsibility for mental health services to large mental health Trusts. For example, mental health services in East and West Sussex are delivered by the Sussex Partnership NHS Foundation Trust, which employs ~5,000 staff (~3,500 full time equivalents), and has a budget of ~£240 million.[61] This is not a good model for the prioritisation, integration and delivery of mental services either locally or nationally. These Trusts should be discontinued and their responsibilities transferred to Clinical Chief Executives for mental services and Regional GP Boards.

### The ambulance service.

The ambulance service in England is run by 10 Ambulance Trusts, 5 of which are Foundation trusts. Each has its own Chief Executive, Executive Directors, Non-Executive Directors and so on. They are large organisations. For example, the South East Coast Ambulance Service Foundation Trust has an annual budget of ~£170 million, covers an area of ~3,600 square miles, and employs ~3,600 staff at 110 sites.[62]

This key service and its skilled and dedicated staff are currently under intense pressure.[5, 63] They are better organised into smaller components each serving a small number of large hospitals and some associated smaller hospitals. An ambulance paramedic would be in charge of each of these components, and be directly responsible to the Chief Executive of one of the larger hospitals in their area of responsibility. The paramedics in charge of each component would coordinate with each other locally and nationally via a tiered Board structure, as for GPs and Chief Executives. This would give the ambulance service a greater sense of self determination, focus and personal responsibility.

The Department of Health should organise discussions with hospital Chief Executives and senior ambulance paramedics to agree a national structure for the delivery of ambulance services. The Ambulance Trusts would then be discontinued, and their staff and budgets transferred to the agreed hospital Trusts.

### Monitoring quality of patient care.

Effective monitoring of quality of care is a central issue for the NHS.

The system currently in place relies mainly on monitoring by Inspectors from the Department of Health of easily measurable criteria, and involves substantial bureaucracy. It makes little use of doctors, nurses and other NHS staff, perhaps because they are seen primarily as the objects to be monitored.

Is it possible to imagine a different system?

It is worth noting some comments made by Robert Francis QC in his report on the Mid Staffordshire NHS Foundation Trust.[64] **"**In the end, the truth was uncovered **.....**.mainly because of the persistent complaints made by a very determined group of patients and those close to them**"**. In his covering letter to the Secretary of State he noted **"**The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur**.....** In short, a system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system**"**.

The system that has evolved in the NHS needs detailed, clinically informed scrutiny, and serious consideration should be given to fundamental change. An informative part of such an exercise would be an analysis of the monitoring systems that have developed in other comparable countries, e.g. France, Germany, Spain and Australia.

Changing the monitoring system for quality of care is not required for the implementation of the proposals discussed in this paper. In fact, it is only *after* the proposals have been implemented and are operating stably and effectively that changing the monitoring system can be considered.

One possibility is a system that shifts primary responsibility for quality of care from civil servants in the Department of Health to Clinical Chief Executives of hospitals and to Chairpersons of Regional GP Boards. The Department of Health would continue to play a crucial supportive role. The Department of Health would also provide an additional and independent level of scrutiny in order to minimise the risk of error, complacency and corruption creeping into the system.

The outline of a possible system is given in Addendum 11. The proposed system is rigorous, but simpler and less bureaucratic than the one that has developed in the NHS. It is likely to be more sensitive at detecting lapses in patient care, and considerably less expensive.

[For further details, please refer to Addendum 11].

## ADDENDUM 1.

### Out-of-normal-hours care (evenings, nights and weekends) in NHS hospitals.

The quality of out-of-normal-hours care in hospitals is of relevance not just to patients admitted at weekends - the focus of the current arguments - but of course also to those admitted on weekday nights, and indeed, to *all* patients in hospitals at nights and weekends. It is worth noting in this regard that junior doctors have complained that hospitals with stretched budgets are skimping on the number and seniority of the doctors resident on duty out of normal hours.

Currently, junior doctors (i.e. doctors at the various stages of their training towards becoming Consultants) are r*esident in the hospital* when they are on duty out of normal hours. It takes ~7 or 8 years of hospital training for a young doctor to become a Consultant, and consequently the level of expertise of junior doctors on duty varies substantially, depending on the stage of their training. Consultants, by contrast (unless their specialty involves emergency medicine, e.g. Accident and Emergency) are usually on-call from home. There are residence limits for Consultants, to ensure that the time they take to travel from home to hospital is reasonably short. If junior doctors on duty out of normal hours have any difficulties or queries, they contact the Consultant on-call by telephone. The Consultant, if they deem it necessary, comes into the hospital. When the problem has been dealt with, the Consultant returns home.

The number and seniority of junior doctors on call at any one time needs examination. Perhaps even the training of junior doctors needs to be considered.

The mortality figures have spurred calls for Consultants to be resident on duty out of normal hours. The BMA has calculated the costs and staff requirements of such a system. If a hospital department with 10 Consultants were to provide one of their number to be resident on call at weekends (48 hours) and weekday evenings and nights from 6 pm to 8 am (70 hours), it would need an additional ~6 Consultants if daytime services were to be maintained.[65] This number takes into account the European Working Time Directive, the fact that "premium' time from 7 pm to 7 am carries more weight, annual leave, and time for support work. This level of Consultant resident cover is unachievable financially, and the Consultants required to implement such a system simply do not exist.

If resident Consultants are deemed essential, perhaps to supplement non-resident Consultant cover, it is likely to involve one Consultant to cover perhaps 40 or 50 Consultants to be financially viable (see preceding discussion). This will of necessity involve cross-specialty cover, which somewhat defeats the purpose of the exercise. An alternative would be resident Consultants for peak periods only, say 8 pm to 11 pm every evening.

The current system of non-resident cover by Consultants might well be the most efficient and cost-effective use of Consultant time, and will probably form the foundation for the future. It is worth noting that the Consultant contract does not oblige Consultants to be *resident in the hospital* out of normal hours. However, Consultants are much more likely to be amenable to changes to their contract if the proposals are made in well considered circumstances.

It is worth bearing in mind that no system is ever going to be perfect, any more than it will ever be viable to provide lighting on each and every road in the UK in order to reduce traffic accidents at night.

## ADDENDUM 2.
## Understanding workload in general practice.

It is worth noting that an important source of practice income are Quality Outcome Framework (QOF) targets and Enhanced Services (ESs). These are intended to improve the quality of clinical care in general practice. QOFs involve financial remuneration of practices for meeting agreed targets in particular areas (e.g. vaccinations). ESs involve, for example, a payment for regular examinations of patients with learning disabilities.There have been over the years in excess of a hundred fundable outcomes and many fundable enhanced services. Income from these sources depends on the QOF targets and ESs the NHS chooses to make available, and on the effort required to meet them. It depends also of course on the diligence with which individual practices pursue them.

When the government introduced QOF targets in 2004, civil servants predicted that GPs would on average achieve 75% of the possible 1,050 QOF points. In fact they achieved 90% - a miscalculation that gave GPs an unplanned (and unrequested) increase in income, and the NHS an equally unplanned and substantial additional expense. The government appears to be making it progressively more onerous to achieve some QOF targets, perhaps to try to claw back some of the unplanned pay increase, but GPs have responded by working harder, in order to maintain income.

The government has occasionally introduced populist QOFs and ESs of little clinical value. For example, one widely trumpeted enhanced service (introduced against clinical advice) involved the early diagnosis of dementia. This is in spite of the fact that there are no effective treatments, the progress of dementia is slow, and to burden an older patient living a normal life with the label of dementia can potentially diminish their quality of life. The dementia enhanced service has now been withdrawn.

It is worth noting that if each of 40,000 GPs in the UK loses one day's work *per year* on clinical or administration tasks of low importance, this is equivalent to losing 170 full-time GPs. Conversely, saving one day's work per annum per GP is the equivalent of employing 170 additional full-time GPs. One should therefore consider carefully what is asked of GPs.

However that may be, there have been several contributory factors to the current workload:

- There has been a substantial increase in the frequency with which patients visit their GPs. The figures show a ~50% increase over 1995 to 2008, from 217 million consultations (3.9 per patient per annum) in 1995 to 300 million consultations (5.5 per patient per annum) in 2008,[66] and there has almost certainly been a further large increase in more recent years. This has several causes, including an ageing and increasingly obese population with an increasing incidence of type 2 diabetes, and a more health conscious and more demanding society more likely to consult their doctor than in the past.
- One important contributor has been QOFs and ESs, which involve a substantial amount of chasing targets and box-ticking.
- The overall inadequacy of out-of-hours cover since 2004 has probably made patients more likely to want to consult their doctor during normal working hours.
- Salaried doctors generally work fewer hours than the gradually diminishing number of partners, and this has increased the workload on partners.
- Over the past few years, GPs have been encouraged to take on specialty interests (e.g. in ENT, dermatology) for a half day or 1 day per week. The objective is to provide an additional layer of triage between GPs and Consultants, and thereby minimise hospital outpatient appointments. It provides an additional interest for GPs and some additional income - but it takes GPs away from general practice.

## ADDENDUM 3.
## Comments on funding the hospital service.

Funding models would need to be discussed and agreed by the Department of Health, the BMA and the Royal Colleges. One possibility might be a capitation based system, with the capitation fee weighted for each specialty. Income for each specialty would be calculated on the population covered by the hospital for that specialty. Some specialist services need to be provided by all hospitals, some by only a few. The geographical areas (populations) covered by each hospital for each specialty would be agreed by the Chief Executives of the relevant hospitals under the chairmanship of the Department of Health, and reviewed periodically.

There are two crucial points. The first is that GPs would be free to refer their patients to whatever hospital they and their patients prefer. GPs will refer patients more frequently to Hospital Departments regarded as providing a better quality service in the required specialty. This decision would be based on the general impression of the Department formed by the GP and the patient, and on publicly available statistics on the hospital's and the particular Department's quality of care (see below).

The second is that the culture of government-set targets for hospitals would be discontinued. Targets that influence funding, especially targets with "tipping points", can have an especially pernicious influence and distort clinical practice and clinical priorities.[26] In their place, each hospital would be required to make available for public perusal on their websites some general indicators of quality of care, e.g. waiting times for outpatient appointments in each specialty, waiting times for elective surgery in particular areas, wait times in Casualty, time to stenting or clot dissolution in patients admitted with myocardial infarcts. The Second Tier Chief Executive Board should discuss this matter with the Department of Health, the BMA and the Royal Colleges and agree at national level which statistics NHS hospitals should make publicly available. This would be reviewed periodically. Thus how the hospital was performing in relation to other hospitals on several agreed criteria would be in the public domain.

The number of new referrals per annum by GPs to individual hospital Departments would be an easily measured statistic, not easily artificially distorted if internal referrals within a hospital are excluded. This could be used to influence that Department's financial allocation.

## ADDENDUM 4.

### Management structure in hospitals with Clinical Chief Executives.

Chief Executives would appoint at their discretion a small Planning and Executive Committee (typically perhaps ~8 or 10 people) representative of the hospital's main medical and surgical specialties, including a senior nurse and a finance manager. Membership of the Planning and Executive Committee would be for 4 years, renewable once at the Chief Executive's discretion. This committee would be responsible for achieving excellence in all aspects of the hospital's functioning, both clinical and non-clinical, and would have absolute discretion on how the hospital was run.

The Planning and Executive Committee would appoint one doctor and one nurse as the designated persons responsible for particular clinical areas, e.g. Accident and Emergency, Intensive Care, individual Wards, Operating Theatres. The designated doctor and nurse would be expected both to deliver a high quality service and to maintain a high quality environment. They would be expected to inform the Planning and Executive Committee if standards were falling, and the Committee would need to put in place whatever remedial measures or resources were needed.

If in the view of the Planning and Executive Committee there were intractable problems with funding, staffing or facilities in any area of the hospital, the Chief Executive would be required to inform the NHS England Board of the problem.

A Chief Executive using this management structure is likely to play an important role in the re-engagement of doctors and nurses with their hospitals. The standards achieved with this system might well surpass the endless, externally imposed targets currently being pursued.

## ADDENDUM 5.
## Funding of Regional GP Boards.

Regional GP Boards would be funded centrally by the Department of Health.

Funding of Board members, including the Chairperson, should have two distinct objectives: firstly to minimise the impact of the GP's absence from their practice on Board duties, and secondly to ensure that GPs do not lose income from being a Board member. Board duties should occupy a maximum of one day per week, except in unusual circumstances requiring Department of Health approval.

If a Board member performs Board duties on a day of the week they normally work in their practice, remuneration *to the practice* to cover the GP's absence should be generous. The funds should be used entirely for patient care. For example, the practice could be funded for 1.5 days of locum doctor cover for every 1.0 day of Board duty. In these circumstances, the GP would receive only a relatively small honorarium (say £5,000 per annum), as they would continue to receive their normal share of practice profits as a partner in their practice.

If a GP performs Board duties on a day of the week they do *not* normally work in the practice, the practice would obviously not be eligible for any additional funding. In these circumstance, the GP should receive say 20% of the average income of GPs on a PMS contract (currently the most financially favourable), i.e. ~£20,000 per annum for 1 day per week of Board duties, plus perhaps £5,000 per annum.

The Board will need to employ support staff. The broad outline of support staff should be agreed nationally and will depend on the responsibilities given to GP Boards. A full-time secretary/PA and a full-time manager/financial manager will almost certainly be needed as core staff. GPs responsible for some areas (e.g. quality of care) are likely to need a half-time or full-time assistant. This would be decided in the light of experience.

The Board would ideally be housed in rooms provided by a local Hospital or Council, if suitable space was available.

Support for such things as websites could be provided at national level, in order to reduce costs for individual Boards.

## ADDENDUM 6.

## A note on funding support staff in general practice.

Consideration should be given to avoiding as far as possible the funding of support staff (e.g. receptionists, nurses) out of practice income. This is to avoid conflicts of interest between GPs' personal income and the level of support staff in the practice. In the past, 70% of the salary of support staff was centrally funded. This is potentially a valuable approach, provided that an upper limit was agreed nationally for the number of permissible support staff of different categories in relation to list size of the practice.

## ADDENDUM 7.

### Distribution of centrally funded GPs during the transition phase in general practice.

Practices would apply to their GP Board to be considered for these posts, and would be eligible if they met “basic staffing” requirements. This is to ensure that the new post was used to relieve pressure on existing doctors, rather than simply to supplement practice income, and also to ensure that the new doctors enter stable practices with good working environments. Eligible practices would be ones where the number of patients per full-time profit-sharing partner would, with the addition of the new GP, fall below the agreed upper limit discussed in the main text. For example, if the upper limit were 2,200 patients per partner, a practice with 10,000 patients, 4 full-time partners and 1 full time salaried doctor would be eligible, as the new GP would bring the number of patients per partner down to 2,000. A similar practice with 10,000 patients, 3 full time partners and a 2 full time salaried doctors would not qualify. Practices already at or below the upper limit per partner (e.g. a practice with 5 full-time partners and 10,000 patients) would also be eligible, provided that the list size per partner was not substantially less than the average list size per partner in the region.[57] It would be a strict requirement of the scheme that practices accepting a centrally funded post would maintain the same number of partners from the start of the new appointment to the end of the transition phase, unless exceptional circumstances arose, which would be adjudicated by the Department of Health in consultation with the Regional GP Board.

Single partner practices would not be eligible. Practices with 2 or 3 partners would be eligible for a half-time equivalent centrally funded GP, and those with 4 or more partners for 1 full-time centrally funded GP. Should the appointed GPs require part or full time parental leave during their phase of central funding, the funds earmarked for this project would have to be used to fund a locum GP. Arrangements for pay while on parental leave would need to be agreed separately at national level.

Strict fairness will not be possible - the important objective would be to provide every eligible practice with some substantial support over the transition phase

The Board would advertise the available posts, and after interview select say 20 candidates for 10 full-time equivalent posts. The short-listed candidates would then visit the eligible practices. Appointments would be made by mutual agreement between the eligible practices and the candidates, overseen by the chairperson of the GP Board. This approach would minimise the risk of favouritism in making appointments. Crucially, once a practice had had an allocation, it would not be eligible for future allocations.

## ADDENDUM 8.
## The funding of general practice premises.

A system is needed that gives GPs a financial incentive to provide premises of a high standard while simultaneously restraining excesses. In addition, in the current volatile climate in the NHS, GPs should be provided with indemnity against financial losses if the premises become redundant through no fault of their own, e.g. a move by the NHS to ICOs. The system should also be simple to administer and not subject to challenge, and thereby keep running costs low.

A rental based on a capitation fee, i.e. dependent on list size, could achieve these objectives. The capitation fee would be weighted for local property prices and for prevailing bank lending rates. The capitation fee would have to be sufficiently generous to be financially attractive to GPs. It could be calculated around the repayment costs of a 100% mortgage over 25 years, plus some extra to cover rates and other costs, for a practice with an average list size.

Calculating the rent on list size would be simple to administer, as accurate list sizes are held by the Department of Health. Weighting of the capitation fee would be done centrally, and not subject to challenge. Limiting rent by patient numbers would also inhibit excessive demands for space. At the other end of the cost spectrum, broad (rather than minutely detailed) minimum standards of premises would need to be set for particular list sizes, in order for the premises to be approved for NHS rental. Premises would be inspected periodically, say every 5 years, to ensure maintenance of standards.

The incentives for GPs in this system is that the practice would immediately have better premises, and there would be slow capital accumulation to the practice over the 25 years of the mortgage. At the end of the 25 years, the premises would belong to the practice and the rental would become part of practice income.

Patients would benefit from a better practice environment. It is bureaucratic pie in the sky to suggest, as is done in the explanatory notes to the £1 billion fund, that funds would be provided only if they resulted in new clinical services, increased patient contact time, and reduced hospital emergency admissions of patients aged over 75.[60]

## ADDENDUM 9.
## Notes on the organisation of maternity services.

Clinical Chief Executives for maternity services would be appointed in precisely the same way as Clinical Chief Executives of general hospitals, including having a local Consultant (chosen by a ballot of obstetricians and senior midwives in the area served by the hospital base) among the candidates

The geographical areas for which individual Clinical Chief Executives were responsible would be defined under the chairmanship of the Department of Health. Clinical Chief Executives should appoint a small Planning and Executive Committee, as for general hospitals.

Liaison with general practice and other primary services would be provided by regular meetings (perhaps every 3 months) between the Clinical Chief Executive and/or the Assistant Clinical Chief Executive with the nominated GPs for maternity services from each GP Board within the catchment area of the hospital.

Liaison with adjacent maternity hospitals and maternity services would be provided by regular meetings with the Clinical Chief Executives and Assistant Clinical Chief Executives for maternity services from perhaps 10 or 15 contiguous areas. These Clinical Chief Executives would comprise a regional First Tier Board for maternity services. Each would elect a chairperson from among their number. The chairpersons of these regional First Tier Boards would collectively represent all midwifery services in England, and would form the Second Tier Board for maternity services. They would elect a chairperson from among their number and meet periodically.

## ADDENDUM 10.
## Notes on the delivery of maternity services.

Simon Steven's report[12] also quotes "recent research" showing that "for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions". The vast majority of women, of course, want as natural a birth experience as possible. However, the evidence for the safety of home births is not so clear cut.[67] Moreover, it is not necessarily the case that fewer interventions is better, given that these interventions are carried out for the benefit of the mother and her child. The reverse might in fact be the case.[68] However that may be, it is a fact that there are unexpected obstetric emergencies which can be detrimental and sometimes fatal to mother and/or baby unless there is more-or-less immediate access to emergency hospital services.

The Rosie maternity hospital in Cambridge has a floor dedicated to midwifery led births, including water births. This is perhaps a reasonable compromise between safety and naturalness in birthing. However, the issue needs more in-depth and clinically informed discussion between obstetricians, midwives, paediatricians and patients before allocating NHS resources to particular solutions.

## ADDENDUM 11.
## Monitoring quality of patient care in the future NHS.

Quality of patient care fundamentally falls into two categories, basic and clinical. Excellence in *basic care* involves paying sympathetic attention to the patient's dignity and daily needs such as cleanliness, comfort, nutrition and peace of mind. Everything hangs on the quality of basic care, because without excellence here patients unnecessarily endure anxieties and discomforts over and above those inherent in their illness, and they lose trust in the very people to whom they have turned for succour. Excellence in *clinical care* fundamentally involves such things as accuracy of diagnosis, appropriateness of therapy, standards of surgical and other therapeutic and diagnostic interventions, rates of infections and so on. This depends primarily on the knowledge, clinical skills and commitment of doctors, nurses and other NHS staff.

Here is one possibility.

Each Clinical Chief Executive would appoint a designated Consultant at their hospital and each Chairperson of a Regional GP Board would appoint a designated GP on the GP Board with quality of patient care as their area of responsibility. The Department of Health would allocate say two specified members of staff to support three or four hospitals in the same geographical area for a set period of perhaps three years, before moving them to different hospitals. Similarly, the Department of Health would allocate perhaps two specified members of staff to cover three contiguous Regional GP Boards for a set period. In addition, a Consultant in a neighbouring hospital and a GP in a neighbouring GP Board would play an arms length supervisory role.

The monitoring system would have three arms.

### *Attributed, confidential complaints system.*

This arm aims to use patients and their families and friends, as well as NHS staff, as front-line observers to identify defects in quality of patient care, especially basic care. Plaintiffs would lodge complaints in writing or via a "Complaints Regarding Quality of Care" section of the hospital website or GP Board website. Complaints would be considered only if plaintiffs provide their name and contact details, and (if they are complaining on behalf of a patient) the name of the patient on whose behalf they speak. The complaints would be available for confidential viewing only by the Department of Health, the designated GP and designated Consultant and one external GP and Consultant. If complaints were lodged by letter, the details would be added to the database to enable easy viewing by the eligible staff and for meaningful statistical analyses.

The NHS in England received 205,289 written complaints in 2014/2015 (around 4,000 per week).[69] Some patients never complain, however badly they are treated. Some complain over minor issues. Rarely, complaints are malicious. Complaints need to be perused and analysed in a way that uncovers individual incidents or especially patterns of incidents of substandard care by individual members of staff or organisations in a way that is fair but does not unnecessarily consume extensive NHS resources

This system is of course entirely distinct from NHS Choices, where comments and complaints are lodged, usually anonymously, for public viewing.

### *Monitoring clinical statistics.*

This is the cornerstone for monitoring quality of *clinical* care.

For hospitals, this arm of monitoring involves the collection of key statistics for each specialty department in the hospital, and their analysis both in-house and independently by the Department of Health and external NHS Consultants.

For general practice, quality of care is more difficult to measure using statistics. However, practices would be required to provide their GP Board with statistics on nominated areas of clinical care, such as rates of childhood immunisations and rates of cervical screening. For Nursing Homes, one important statistic is a continuous assessment over 24 hours of the staff/patient ratio, including duties and qualifications of staff. For other areas of primary care, such as district nursing and social care, the principal deficiency for the next few years is likely to be the adequacy of provision, which will need to be assessed.

*Site visits by the Department of Health.*

Small groups from the Department of Health (perhaps three or four members of staff) would pay one-day annual visits to every hospital in England, including one-day visits to each mental health service and each maternity service. They would be hosted by the Clinical Chief Executive and the designated Consultant for quality of care. For general practice, there could be annual visits of 2 hours' duration by Department of Health staff to every practice. This would be hosted by the designated GP for quality of care in the Board area.

Over and above these three arms of monitoring, Clinical Chief Executives and Chairpersons of GP Boards would aim to develop a culture of personal and collective responsibility.

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## ACKNOWLEDGEMENTS.

I would like to thank Dr Timothy Chevassut MA BMBCh MPH FRCP FRCPath PhD (Senior Lecturer and Honorary Consultant in Haematology, Brighton and Sussex Medical School, Brighton BN1 9PS), Mrs Scarlett McNally BSc MB BChir FRCS (Tr&Orth) MA MBA (Consultant Orthopaedic Surgeon, Eastbourne District General Hospital, Eastbourne, East Sussex BN21 2UD) and Dr Clarissa Fabre MBBS DCH MRCP (General Practitioner, Buxted Medical Centre, Buxted, East Sussex TN22 5PD) for critically reading the manuscript and for their helpful comments and suggestions. I would also like to thank Dr Xavier Nalletamby MBBS DCH DRCOG MRCGP (St Peters Medical Centre, Brighton, East Sussex BN1 4LA) for advice on levels of GP cover used in GP Cooperatives of ~2004.