Implications of the NHS Bill

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The NHS Bill is now the NHS Act, ushering in huge potential changes in medical services across England and with potential knock-on effects across the UK, despite the diverging healthcare systems in the four nations.

The publication entitled Never Again by Nicholas Timmins, a senior fellow at the Institute for Government and the King's Fund, asserts why the then health secretary believed that never again – or at least not for the foreseeable future – will the NHS need to undergo another big structural change. By placing the reforms within primary legislation, the bar has been raised. Traditionally, newly-elected governments rarely spend valuable parliamentary time undoing the legislation of the previous administration. They want to push on with their own reforming, and hopefully vote-winning, measures rather than look back to the past. Whilst at present the Labour Party is committed to repealing the NHS Act, it is more likely that if elected, they will run with those new structures which work and leave those which don't to simply wither from lack of resources.

Although the exact numbers are constantly changing, the NHS Commissioning Board will devolve approximately £80bn of public money to over 200 Clinical Commissioning Groups, each buying health services for populations from as small as 70,000 to as large as 1 million people. General practitioners have been given a huge role in determining whether this will work on the ground. It is envisaged that all NHS Trusts (there are over 150 acute trusts and over 50 mental health trusts in England) will achieve Foundation Status by 2014 and their performance will be judged by Monitor (finances) and CQC (quality of care) with the disappearance of Strategic Health Authorities. Local Authority social care and education will sit down with NHS health to hammer out local priorities in Health & Wellbeing Boards, in theory held to account by local HealthWatch 'consumer representatives'. Locally, public health doctors will sit within the Local Authority whereas Public Health (England) will have the wider remit of nationwide issues, eg pandemic readiness. The potential roles of Clinical Senates and Clinical Networks are still under discussion.

The £20bn savings in the NHS have been described as cuts, but in fact under the last Comprehensive Spending Review the NHS was given a 'flat' settlement of around £110bn. ie no uplift with inflation. Therefore, the £20bn represents 'efficiency savings' necessary to pay for new, expensive treatments, to cover inflation and to deal with the secular drift to an older population requiring more medical care. The irony is that as medical and scientific ingenuity develop new treatments and technologies, financial costs and public expectations may also rise. Whereas vaccines, for example, may save both lives and costs, by preventing disease and reducing the demand on primary and secondary care, it is doubtful whether the same could be said of MRI scanning.

Approximately 40% of the NHS budget is spent on the salaries of over 1 million employees. One way to make 'efficiency savings' in the NHS is, paradoxically, to reduce access to care. For example, if operating lists for hip replacements are reduced and waiting times are allowed to rise, the NHS expenditure may go down (assuming fewer staff are employed). However, social care costs may rise if these patients need more assistance in the community to fulfill their daily activities. This is a danger of the 'silos' of government departments when the desire to protect one budget has unforeseen consequences on another part of the welfare state.

However, there are other pressures which suggest government, and beyond April 2013, the new NHS Commissioning Board will find it difficult to balance the books by a reduction in services. The final Francis Inquiry report into Mid-Staffs has now been delayed until early 2013, after which the Secretary of State will have to respond formally to Robert Francis' recommendations. Whilst the nursing and medical professions are likely to be in the firing line along with the regulators (eg CQC, GMC, NMC), the Secretary of State has already pledged to make long-term conditions and those suffering from dementia two of his four big priorities for the remainder of this parliament. This would suggest that Francis' recommendations in regard to these two groups will not be ignored lightly. The challenge becomes greater by the day. By 2030 there will be 2.6 million UK citizens aged over 85, instead of the current 1.1 million, and it is predicted the number of people suffering from dementia will have doubled to 1.4 million.

It may be that the direction of travel will be to enhance care in the community, "the best care as close to home as possible", but costs will not be kept down unless this is accompanied by a further reduction in secondary care beds. The last two decades have seen a reduction by one-third of inpatient capacity in the UK, highlighted recently in the RCP report Hospitals on the edge? The time for action, with ever shorter lengths of stay and a tendency to re-admissions ('revolving door medicine'). Over those two decades, numbers of admissions have increased by one third. The RCS and Age UK have also drawn attention in their recent report Access all Ages to implicit rationing of surgery on the basis of age, and there will be pressure to treat on the basis of clinical need and objective risk/benefit, ie on 'biological age' rather than 'chronological age'.

The new structures brought into play by the NHS Act were designed partly to encourage a bigger role for the private sector in providing healthcare. Historically, less than 10% of healthcare in the UK has been provided by the private sector, mostly outside the NHS with the patient paying directly or via an insurance scheme. An expansion in private healthcare provision is not, however, necessarily synonymous with an expansion in this 'fee for service' type of private health industry. It can also take the form of care which is free to the patient at the point of delivery, with the taxpayer reimbursing the private sector for the care which the private company provided.

So much for the Act. Most of the medical profession seem to be of the view that these organisational changes, of which this is the twentieth in as many years, do not go to the heart of the problems of the 2012 NHS. Most doctors think that what we urgently need is service re-design. Reports over the last couple of years from the RCPCH, RCOG and RCP have all flagged up the difficulty of maintaining high quality, acute services across over 200 sites in the UK. Whilst there is an undeniable need for 24/7 hospitals in

remote and rural areas, many of our hospitals are, for historical reasons, within 30 minutes' drive of another hospital. Does London really need 40 acute hospitals?

In medicine, there is often a relationship between quality of outcome and volume of caseload. There needs to be more of a public debate about treatment as close to home as possible vis a vis care which delivers world-class results. The designation of fewer, larger trauma centres; eight acute stroke centres for London instead of 32; and seven safe and sustainable paediatric cardiac surgery sites for England instead of 11 illustrate the benefits which can accrue. Highly technical, high-risk specialities need to be co-located with sufficient critical mass to ensure 24/7 cover and optimal training of tomorrow's specialists. Doctors recognise these are not easy issues for MP's, elected by and accountable to a local community who will not relish a reduction in services locally unless we as doctors articulate the benefits. Talking about hospital closures is a distraction – most sites will still offer local outpatient clinics and ambulatory care for part or all of the day. However, that does not mean every site needs to have inpatient beds and the full panoply of intensive care and all acute services 24/7. Of course, to make these changes work well, we will need prompt and well-trained retrieval and transfer services, and local health care services must be able to perform initial resuscitation and stabilisation of any unexpected cases on site.

Facing up to these competing challenges of economic austerity, more expensive care, organisational change and service re-design, I believe the medical royal colleges have much to offer. The colleges speak for the great majority of the UK's 200,000 licensed doctors on behalf of safe, high quality care for patients and the public. They are charities, not trade unions, and their members carry a wealth of experience and professional expertise. They are well-placed to provide expert clinical advice in dealing with these 21st century challenges. Indeed the Academy of Medical Royal Colleges is working with the NHS Confederation and National Voices on a project to identify the principles and good practice which should underpin the changes required by service redesign.

What will the NHS look like 10 years from now? The optimist in me says that if we can finally overcome the IT nightmare that was NPFIT and deliver a joined up patient e-record, things could be much better. Like the 'cloud' for my laptop, tablet and smartphone, it would be wonderful if every time I had a consultation, anywhere in the UK, with any doctor, nurse or pharmacist, that my basic medical history was available with my current medications. General Practice has had such systems for 30 years. Why do hospitals still lag behind and could this information be available beyond my own GP? Could I not carry my own information on a smart card?

Tele-medicine may also enable better care initiated by the patient at home. Already pilot studies have shown that diabetic patients can upload their daily blood sugar results by telephone or internet and receive advice on management. Near patient monitoring for coagulation studies and blood pressure could allow similar innovations, avoiding the need for attendance at health services.

Looking specifically at the future for doctors, in ten years revalidation should be bedded in and, hopefully, working to improve standards. It has been a long time coming, but being able to reassure the public that their doctors are fit to practice has to be the right thing. In ten years we should also be seeing the fruits of whatever emerges from the current hugely significant "Shape of Training" review of postgraduate medical education now underway.

The pessimist in me worries that by 2030 the UK is predicted to have 11 million obese adults. Already, one-third of school-age children are

overweight or obese. If nothing is done to avert this trend, the demands on the NHS for management of type 2 diabetes, hypertension and heart disease could swamp the service. In addition to these well-recognised associations with being overweight, obesity is now also recognised as a major risk factor for cancer. The Academy of Medical Royal Colleges will publish a report early in 2013 setting out the views of the medical profession on this hugely important public health issue.

Many challenges lie ahead for those of us who work in the NHS. But the NHS remains the envy of many countries because it provides care on the basis of need, not the ability to pay. Other countries spend a larger percentage of GDP on health but often the difference is largely accounted for by transactional costs - the bureaucracy required so that the healthcare provider can ensure that the patient's insurer is billed for every last needle and plaster used during the patient's care. Analysis by the Commonwealth Fund in the United States shows that the NHS provides unparalleled value for money. Since there is not likely to be more money in the near future, that is something to be proud of. ■

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