Professional Flaws by Lord David Owen, February 2013

The flaws in the structure in the NHS in England go deeper than just the Health and Social Care Act 2012, which I hope might be corrected after the next General Election through the National Health Service (Amended Duties and Powers) Bill which I presented in the House of Lords on 28 January 2013. Many conclusions meanwhile will be drawn from the Francis Report, but one question needs to be asked by the caring professions, namely, why was the professional voice of the Royal Colleges not heard loud and clear about the erosion of professional standards in the NHS in England?

As so often when analysing the future, one has to draw on the past. There is no better place to start than an article by the social historian Sally Sheard, 'Quacks and Clerks: Historical and Contemporary Perspectives on the Structure and Function of the British Medical Civil Service' (*Social Policy & Administration, 44/2, April 2010, pp 193-207*). It shows how successive Whitehall efficiency reviews between 1979 and 1994 merged the parallel medical and civil service reporting lines in the Department of Health. The effect was to reduce the Chief Medical Officer's ability to call directly upon the support of medical civil servants. Between 1960 and 1973 Sir George Godber became the most influential CMO to advise Ministers. He insisted on having direct line management of the medical civil servants, who by 1968 numbered 127 in the DHSS and 62 in the regions. Godber ensured that medical expertise was acknowledged and medical policy was appropriately developed, by obliging the parallel hierarchies to agree recommendations before they could go forward to Ministers. That was the system which operated when I was Minister of State for Health in 1974 – 1976. That does not operate today.

Sally Sheard recalls that Margaret Thatcher is reputed to have known the exact number of doctors working in the DHSS in 1979 and to have told Patrick Jenkin, her new Secretary of State, that one of his first objectives should be to send many of them “back to the NHS to do proper jobs". In its contempt for coherent management it may prove one of the most costly 'penny wise pound foolish' moments in the history of NHS management. It

was also in defiance of the judgement of her own ideological 'guru', Sir Keith Joseph, who endorsed parallel hierarchies when he had been in charge as Secretary of State for Health and while introducing legislation in 1973 for a three tier re-organisation. Later in the Thatcher government, when Chancellor of the Exchequer, Nigel Lawson developed very important general guidelines about the economics of health care. "Simply stated, the demand for health care exceeds the supply". There is only a given amount that any society can afford to pay on the total health bill, public and private. He argued against making all personal subscriptions to BUPA and similar private health insurance schemes tax deductible because it simply boosted demand. He claimed, for example that giving tax concessions to the private sector, without improving supply, would result not so much in a growth in private health care, as higher prices. The key for him was in the supply.

Lawson also argued as a self confessed 'arch promoter of privatisation' in his autobiography that "the provision of medical care is *sui generis*, and should not be assimilated to other activities where full-blooded privatization is entirely appropriate." (Lawson, 1992:615 and 616)

There were eight reviews of the Department's medical staff numbers between 1981 and 1994. A further restructuring in 1995 led the former CMO, Sir Donald Acheson, to tell the 1998 BSE Inquiry that this had left staff numbers so low that it was difficult to see how any future CMO could discharge his responsibility effectively or "successfully insist, against opposition, on any necessary changes to address any new problems or emergencies". Another CMO, Professor Kenneth Calman, reportedly claimed his staff now consisted of a secretary and a mobile phone.

The care scandals in the NHS, including the most recent and most serious, the Francis Report on Mid Staffordshire NHS Foundation Trust, have their roots in not just politicians but top civil servants disregarding inconvenient and sometimes costly professional advice from nursing and medical professionals. The Francis Report shows how artificial target figures and counterproductive incentives have been allowed to distort and mangle true evidence based standards of health care. This has happened under Labour and Conservative governments.

The medical profession and the Royal Colleges in particular need to ask themselves whether they have fully lived up to their Royal Charter obligations and have maintained their professional independence. Have they been embraced and then incorporated by the Department of Health? This question was asked when it was revealed how the Royal Colleges had failed to stand up to Sir Liam Donaldson, the CMO between 1998 and 2010, and the Secretary of State and Ministers in the Department of Health over the 2007 Medical Training Application Services MTSA scandal. These proposed reforms to the training and career paths of young hospital doctors were supported unconditionally by the Royal Colleges. Why? Was it because the Colleges were and still are hugely dependent on Departmental funding for their ever-growing post graduate training programmes? Very worthwhile these educational activities are but not if that degree of financial dependence leads the Colleges becoming compliant in Departmental decisions which impair professional standards. It is an old adage that he who pays the piper plays the tune. For the Royal Colleges to recover their independence, it may be necessary to change the source or mechanism of payment for their educational activities so that they do not feel compromised in challenging the Department of Health about standards and policies within the NHS.

On 16 October 2008 in an after dinner speech at the Royal College of Physicians following Professor Sir Michael Rawlins' Harveian Oration, I warned of the perils of being embraced by the Department of Health and then of incorporation. Judging from the supportive comments afterwards, many present were aware of the need to avoid this happening again. Then in 2010, instead of formally consulting their members on the professional aspect, not the politics, of the Health and Social Care Bill, when its framework first became known, the professions' leaders and some Royal Colleges left it to the BMA to deal with the CMO and Secretary of State. It was yet another indication that the Colleges were becoming too close to the Department and were losing their precious independence. Eventually, many were forced by their rank and file members to consult, and this revealed that a massive gap had developed and that the membership was highly critical of the government legislation.

There is now a new opportunity for the medical profession to examine these reforms. I hope they will carefully consider my Private Members Bill, which is aimed at reinstating the democratic and legal basis of the NHS in England. Any new government coming into office in 2015 and minded to introduce urgently the National Health Service (Amended Duties and Powers) Bill 2013 that I presented to the House of Lords on 28 January 2013 will have to examine the enfeeblement of professional advice. There are many ways in theory of reasserting the professional advice and professional standards on which the NHS in England relies. I suggest Royal Colleges individually, and collectively, should give this issue the greatest priority. They must learn from their past failure and earn their members' support by starting a professional study and consultation on maintaining their authority.

A place to start might well be in considering three documents. First, Harry Burns's article 'Health Tsars' (BMJ, 15 January 2004, pp 117-18), which concluded that these tzars had proved their effectiveness because they were practising clinicians. Second, an interesting report for the National Institute for Health Research, 'Possibilities and Pitfalls for Clinical Leadership in Improving Service Quality, Innovation and Productivity' by John Storey and Richard Holti, (January 2013). They praised what they called high impact leaders who brought an appropriate scale of ambition and a set of micro-political capabilities to bear so as to achieve significant cross boundary service redesign. A different, but no less important, study going far wider than the NHS is 'Policy Tsars' which sees this development as "here to stay but more transparency needed" (King's College London, December 2012) by Dr Ruth Levitt and William Solesbury. They show how tsars have become a major source of external expertise that many Ministers draw upon and that their influence in Whitehall has grown progressively more significant over the last fifteen years although transparency about their work is patchy. The majority of the 260 tsars they reviewed were found to have made useful contributions.

Yet tsars have their limitations and, while valuable, need to be accompanied by a permanent professional core with an institutional memory and broad experience. Well before 2015 all those concerned that the democratic accountability of the NHS in England is reinstated will need

to have worked out how such internal and external appointments can be quickly brought together to ensure an incoming Secretary of State for Health has quality of professional independent advice to help him or her judiciously intervene without yet another massive reorganisation to ensure that the values and principles of the NHS are restored and reinstated in England.

Overall, three changes are needed. First, the Secretary of State for Health and Health Ministers must be appointed by the Prime Minister with the intention that for at least 2-3 years they will stay in post so that there can be greater continuity and stability in shaping policy. Second, those politicians must receive quality strategic analysis and professional advice from the Department of Health. The advice they receive must combine the expertise of civil servants and NHS managers with a combination of permanent and seconded staff from medical practice, nursing, social work and the allied professions. Third, the reconfiguration of the NHS must be evidence-based. Whatever rationing is introduced, explained to the public and democratically defended.