The People's Inquiry: One Year On

Evidence presented by Dr Gee Yen Shin (GS) and Andrew Barton (AB), London region BMA.

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Central Hall, Storeys Gate, London SW1H 9NH

Present:

Roy Lilley (Chair; RL); Dr Louisa Irvine (LI); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
We wrote last year a report, *London's NHS at the Crossroads*, which made recommendations. We're a year on, we're re-visiting that report with a view to see where we are, what progress we've made, and so on. We're very grateful to you for coming this morning to give us the BMA's view on London's NHS.

GS:
I will apologise, because I don't have any sort of academic paper prepared; I've seen the other speaker [Dr Philip Howard] with lots of figures. But we can give you perhaps a broader brush of what I think are the main, salient issues facing the NHS in London.

I think some of the issues which probably the other speakers spoke about – I had the advantage of hearing Dr Sandhu's presentation – are affecting and happening in London which I think are of central concern are the trend towards huge consolidation of NHS organisations in London. We've seen basic formation of super-trusts, like my own trust – just to be clear, I work for Barts Health NHS Trust as an eye consultant, my employer is actually Public Health England. I am based in a small team within that trust and I am also a member of the BMA London Regional Council.

Barts Health is a perfect example of this huge consolidation of NHS trusts centred around a large teaching hospital, and then absorbing or taking over neighbouring district general hospitals. This is mirrored across West London. The Imperial cluster is a very large example of this. There are other examples of this across London. I think this is a trend which is obviously here to stay, because I think people are tempted to gain economies of scale.

At the same time, it allows the powers that be in those areas to potentially reduce certain services and to try and consolidate themselves into one big site under the banner of pseudo-specialisation. I do understand that in some examples, for example advanced trauma care and ex-stroke care, there is evidence which supports consolidating specialist units in this model. But I think in other terms, for example general acute medicine, for all the acute lists which any hospital faces I am not sure where the evidence base for that is. I think for stroke and trauma I agree there is some evidence for this.

I would be interested to see if there is any data to show that has increased London's capacity to deal with acute medical problems and London's resilience to face for example winter pressures. Acute respiratory infections are very common in winter and we are coming into those pressures now. I see that most parts of the country are struggling under the strain of the annual problem of winter pressures.

I think in London that this consolidation has inevitably led to probably a reduced capacity to cope not with unusual winter pressures but any unexpected problems, for example pandemic flu. It's difficult

to know how these changes would affect our capacity to cope with that. As we know from 2009-10, the bad influenza stretched our resources. I think that's one trend.

I think beneath that, there is a part A or part B of that. I don't know how much evidence you have from other pathologists in your Inquiry, but one phenomenon which is gets very little media attention is the dramatic changes in pathology services. That's really been exemplified in London, which has really been the vanguard of this phenomenon. This has really gone almost unnoticed. In contrast, when you have private sector partnerships for clinical care that really gets media attention. But I think pathology services, because they are behind the scenes, they're a rear echelon support service, so this really doesn't get reported.

As you may know, the Carter Reports 2006-08 led by Lord Carter (I think it's valuable to view the model under which healthcare is provided) were very significant reports which led the way to consolidation of pathology services. It's called modernisation. Whenever we hear the word 'modernisation', it always means consolidation of some kind is coming. That was one report. The second opened the door for private sector involvement, to any provider who can come in and deliver the service required, even as a large private company. That is what happened shortly after that report. In London we have two of the most significant examples in the country of private-public partnerships, firstly by Serco with Guy's and Thomas's and later King's College Hospital. That was initially born as GSTS and is now re-branded as ViaPath. I have to declare I may have a financial interest in Serco through indirect share ownership.

That's one example. That's had a lot of interesting press, a lot in *Private Eye*, and some people could say that it must have been the truth to be in *Private Eye*, so there have been problems with that partnership in terms of its costing the trust more than they thought, and there have been some quality issues reported, so there are some potential issues there but I don't work there so I don't have first-hand knowledge of that.

The second example is a company called The Doctor's Laboratory (TDL), which is a subsidiary of a very large Australian multi-national diagnostics company which deals with both pathology and virology, and that's partnered with UCL and most recently with Royal Free Hospital and all of their associate hospitals. UCL as you know is a very large conglomeration of NHS entities in London. A very well regarded trust, definitely that, but it is a confederation of NHS organisations. The Royal Free has joined that partnership as well. In addition TDL has a footprint in North-West London through Northwick Park, they won a contract to provide pathology services there.

In London, we are definitely at the forefront of privatisation of pathology services. I know that many of my BMA colleagues in the last several years have been greatly exercised by privatisation in the NHS, and Keep Our NHS Public is of course involved with that. I kept telling my BMA colleagues, years ago, 'I know you are concerned about privatisation in hospitals and clinical services but it's actually happening now in pathology'. Pathology was the back door to all of this. Unfortunately it appears to have gone without that much media attention. I understand that people are very concerned about clinical services, so called front line, headline services of A&E and outpatients in the hospital, but these very large multinational companies now actually have a footprint within very well known NHS trusts.

I don't have any evidence that that's harmful, but I think for people concerned about privatisation of the NHS and increased private sector involvement, these are very significant inroads, which are then subsequently followed by clinical services, for example GU services, urgent-care centres, and things which I am sure you are very well aware of.

The other thing to mention which really concerns me – and certainly because of Barts Health I am very aware of it, and which you came across last year in your previous Inquiry as well, is the massive burden of PFI. I know people talk about this all the time, and it's just a repetitive mantra. But when you work in a trust which has that kind of massive PFI debt you realise the actual impact it has. Barts Health has a very nice, new building out at the Whitechapel site which is very impressive. Apparently it cost £1.1 billion to build. I was a bit shocked myself to find that information last year. They don't talk about it much, and always quote the £1.1 billion figure. That's the tip of the iceberg. The iceberg under the water you can't see is actually a £7.1 billion PFI debt which has to be paid back in large annual chunks. The trust will have finished paying back by 2049, so that's 30 plus years of financial distress.

Working in the trust, we find it very difficult to avoid that realisation that we are in a very difficult financial position – and that is an under-statement. I think last year the trust had to pay altogether £137 million to re-pay the PFI debt. That is a huge amount. This annual repayment will rise to about £200 million by about 2025-30, which is only 10 years away. I still don't see how we can keep our head above water. To deliver good-quality services and to balance budgets and books to that kind of scale, I don't envy the management of the trust. It's a gargantuan task.

That's replicated across London. I know at St George's they have a PFI project there. Although the scale is much less, the principle is the same. Then I am sure you will have heard the sorry tale of South London NHS Trust, where they also have huge problems of that nature. I know London is not unique but I think London does have a number of significant number of PFIs, the largest of which is at Barts. That exemplifies a risk because organisations which come to such difficulty, can get taken over or go into special measures.

I don't know as a consultant within that trust how we are going to deliver, how we work under those conditions. It seems to me the priority is financial survival rather than clinical care. We do serve a very deprived and very large population, I think one of the most deprived if not the most deprived populations in London. They need us, and we need to be able to deliver. It seems to me we are on a knife-edge financially, and that is a difficult position. We all come to work and do our best but we are conscious that the resources available are extremely limited. I think is mirrored across London in any place which has PFI projects.

If I was going to say what can we do to try to save the NHS, I think we need to mitigate the PFI debt. I am sure cancellation is probably legally impossible but I think re-negotiation is something that needs to be looked at. Because when I go to meetings, almost every time the dominant feature is finances and resources. I know that for example I speak for my own section which is microbiology we are relatively under-resourced in terms of consultant personnel. That's just an example. This is one of the problems. We are very willing to deliver good-quality care, but we don't have the resources. It's not the current management that's at fault but it's a legacy which casts a long shadow. That's yet another threat.

In terms of London those are the main things that we've come up with. Andrew has another one or two.

AB:
I was interested in Dr Howard mentioning the London Quality Standards. Soon to follow, there will be the primary care standards that Clare Gerarda was working on for NHS England, London. I don't know if the Inquiry has received information about those and how they are used and operated to supposedly improve standards and quality. It's yet another layer of monitoring and assessment in a sense, so the CCGs in London have used the London standards that Dr Howard referred to, to assess

whether the trusts that the CCGs are paying for in each area are meeting their requirements and therefore will continue to get paid, in essence.

RL:
Can I be the devil's lawyer for a moment, and just ask you to look at it another way? I am really interested in your point. These standards are I think quite clever because whereas previously reconfiguration has been head banging and really difficult and this hospital needs to stay and that hospital doesn't and all the palaver we've got in South London, and how the public end up marching through the streets, I think this is quite subtle isn't it? This is saying 'If you want to provide this service that's fine, then you look at the standards'. Then no one's going to argue with the standards. We might have an argument at the margins over the standards and what the evidence base is for the standards, but fundamentally we will end up with a set of standards. So if you've got three hospitals and two of them can't reach the standards, well sort yourselves out within the available cash envelope or stop doing it because it is not safe. As a member of the public, I kind of go for that. It's clever isn't it?

AB:
It is very clever. I agree with you, it's very difficult to have an argument about the set of standards that are going to improve the quality for people on the ground. As a member of the public I feel the same. I think the issue is you've got to take it alongside the comments that Gee has been describing where there's this focus on finance in these trusts that are having to meet these standards. I don't think there's any evidence but there's a focus on ticking the boxes and making sure you meet these standards, but actually the real focus is on always looking at the finances and trying to pay off these debts.

RL:
It's trying to distract you as a magic trick, isn't it? Distract your eye from the finance and ask you to say 'forget the finances we're trying to have a safe hospital'. Which is quite clever.

AB: 'We're trying to improve the quality', yes.

RL: What is the BMA's position on PFI and what is the BMA's position on funding more generally?

GS: I think for PFI at our Annual Conference we set policy for the Council. I'm pretty sure the general feeling is against PFI.

RL:
In the debate last year the BMA condemned PFI, but it didn't really take us any further forward in how to deal with the existing legacy debt. Because some PFIs, for example just down the road at University College, London, a huge PFI there, is managing very nicely although it is running out of money now and will be given a bung before the election. Not all PFIs are in debt, are they? Not all PFIs are making local health economies unmanageable.

GS: That's true but there's the sheer scale of for example the Barts Health one, because there's a smaller PFI at St George's.

RL: So what is the BMA's position? What is it saying? Buy the PFIs out?

GS: I am not certain a solution has been offered, because as I've mentioned I am sure there are huge legal obstacles in terms of these are big multinationals on the other side of the PFI. I am sure they can spend a lot of money on very expensive lawyers.

RL: So we're just stuck with it?

GS:
I think there are a couple of options. One could be of re-negotiation for a more reasonable repayment rate. I also understand, although I don't have details, that Boris Johnson was successful in reversing or tackling a PFI arrangement we had with TFL. I can't remember the details of that.

RL:
It depends on how the contract is cast. There was a PFI hospital in the North East where they were able to use local authority funding to buy it out, but it's only if there's a buy-out clause. For most of them there isn't a buy-out clause.

GS:
Yes exactly. All PFI arrangements are different, with slightly wording with differences, depending on what the NHS management have said.

RL: So the BMA position is 'We don't like PFI but we haven't got much of an alternative'?

AB: It's probably similar to many other organisations' positions.

LI:
I think it's not the BMA's job to work out what the alternative is, it's the job of the government to work out an alternative. The BMA is saying 'we don't want it'.

AB: Absolutely.

RL:
What about the BMA's position on the money more generally? We've had the autumn statement, we've found £700 million down the back of the sofa, what's the wider position? Hypothecated increase in taxation?

GS:
I am not sure there's been any discussion, certainly at our recent LRC meeting, we didn't discuss that particular point about the autumn statement. Of course, all that finance is welcome but it how it's distributed. It sounds like a big number but when you look at the whole NHS economy it's not.

RL: We're just getting our own money back.

PT:
To take you up on the privatisation of pathology services. Why did it happen? Why did they win the contract? What was the process? Where does it lead to? And does it mean the NHS now no longer has the capacity? Does the capacity wither away when it goes out so that it will be with them forever?

GS:
I think the driver is that pathology is basically completely unloved by anybody. If I was a chief executive of a trust and I needed to save a lot of money, I would hive off as much as I could of pathology.

PT: Did it save a lot of money?

GS:
It reduces some of the cost because the staff had transferred over. There are different arrangements. It reduces responsibility and it helps with budget lines, by transferring a lot of the pathology assets and people, and they have set up joint measures in house so it goes in as a separate legal entity and that shifts a lot of the costs. In addition, I suppose it's hoped that the private partner will bring in greater efficiency savings and certainly the companies involved want to get more business, and they are probably better at that than the NHS to be fair.

PT: What do the savings consist of? You say it's dragging down some of the costs? What's the major ingredient of the saving?

GS:
I think a lot of it is staff costs. Also the company retain rents, for example for lab space. I won't say I am an expert on the deals but clearly it is financially attractive to all the trusts which have signed up. They get a partner which is good at things like logistics, IT. Whether that is an advantage in real life in some of the cases is a different matter. For example, for Serco there has been adverse publicity about what's gone wrong there. But the theory is that we shift staff over to this new entity, we shift pension liabilities, staff get less good deals when they transfer over. Some of them have maintained the NHS pension, some have not. The new staff will not be covered by the pension, so that's an immediate saving.

These companies are multi-billion pound multinationals, so they've got deep pockets and they bring new investment, they bring new equipment. I have had the privilege of visiting the Northwick Park lab for example, and that is a really brand new, very impressive lab which probably wouldn't have been possible if it had remained in the NHS.

I am not going to be dogmatic. That has led to a better equipped lab than had it been purely NHS because of the money. The private funder could afford to bring that in. However, the strings attached are that the NHS loses control really. Who has final say? It's the private partner, in these entities.

I was at St Thomas's when Serco came in, but only for a few months as a locum. Before that, we had management meetings in our department, and the consultant was clearly in the driving seat, obviously in partnership with the scientists for scientific outlook, but we were in the driving seat. But literally the day after the private partner came in, the whole tone of the meetings changed: the private sector managers were clearly in charge, and we were there purely in an advisory role.

PT:
So 10 years, 20 years down the line how does that begin to look and will they be embedded in that contract so they could never lose it?

GS:
No, for example the Guys and St Thomas's Serco contract is in the public domain, that was a 10-year contract, I think there are exit clauses where basically if the private partner or the NHS trust felt this was not in their interest any more – so for example if Serco felt they were not making enough money from it – they are able to pull out with a certain amount of notice. I'm not sure of the penalties. So it's not a permanent thing. It is potentially reversible but the main driver of that reverse would come when the private sector partner feels it's not making enough money.

RL: The Carter Report was pretty slow, it hung around for ever before anybody really got to grips with it didn't it? Don't you think over 10 years now, near-patient testing is going to eclipse laboratory tests? We are going to see so many more of these tests in the GP's surgery, effectively while you wait. Right across Europe, they are doing that.

GS: That is true for quite a few tests but I think there will be many tests where that is not possible.

RL:
I accept that the more esoteric complicated testing might be needed in hospital; but the bulk of what GPs want, the fundamental basic tests, most parts of Germany and France they are now done in the GP's surgery, near-patient testing, takes 20 minutes.

GS: Potentially, as long as in those settings they are able to have their quality-management systems.

RL:
They aren't stupid in Germany, they're not stupid in France. Why can't we do it here? It's a kind of professional resistance, isn't it?

GS:
I am not saying it's not possible. So even in hospital we have an in-patient system in many A&Es and ITUs, I have no objection to that. But we still get millions of samples per year, and we certainly have better quality management framework within the lab. But I agree. Near-patient testing will definitely take a greater and greater share of the pathology. I am not going to sound dogmatic.

RL:
If that does happen it takes the soft money out of the contract and at the end of 10 years, we may well hear Serco – who have already pulled out of their clinical contract – might say 'you know what, there's no juice in this and we're not going to do it'.

PT:
If you had been a manager who was as desperately short of money as we're hearing, would you have struck this deal and said 'this is actually a good deal, this is going to cost us a lot less, and when it comes to it front-line stations come first'?

GS:
If I was a manager and not a doctor, potentially I could have been sold that line, but as a doctor and someone who thinks the NHS should really be in public hands, I think I would have looked very carefully at that. I think I would have looked at the partner; and Serco – although I had a small indirect financial interest – is an interesting partner given it's involved for example with the Atomic Weapons Establishment which builds, maintains and designs Trident nuclear warheads.

It's an interesting mix of business portfolios to have nuclear weapons and healthcare at the same time. At the time I didn't feel comfortable with that particular partner. On the other hand, TDL or something like that is a pure healthcare company. From an ethical point of view I would have chosen myself personally a company which has less baggage, although Serco has expertise in outsourcing. That's my personal choice.

In terms of pounds and pence it may have made sense at the time and nobody could have predicted any of the hiccups that came down the road, so I can see the benefits. The Northwick Park lab is a very impressive, very well-equipped lab but the clinicians are not in the driving seat: we kind of in the co-pilot's seat. I think ultimately head office somewhere probably in Australia has the final say in

really big decisions. As a professional I think we lose a significant amount of our leadership role and our autonomy. In that way I think partnerships may be losing their full value of our professional knowledge and experience.

SR: So are you saying doctors will cease to have the say over what tests are carried out on patients?

GS:
I think we would have a decreased say because I think I can probably guess very confidently that if it was suggested tests were not profitable they would not go ahead. Whereas in the NHS we would choose tests which are clinically necessary and somewhere within the NHS we would provide that. If you are in private partnership, the bottom line is you've got to make X% profit a year. If there is an unprofitable service which is still clinically relevant…

PT: What sort of thing? Can you give us an example?

GS: Small-scale, esoteric tests.

FW: You had a toxicology unit there, at St Thomas's?

AB: I think it was closed down.

GS: Basically anything rare and esoteric and very low volume technically difficult would fall into that category.

PT:
As a doctor, could you get that test from somewhere else? If you really wanted to have this patient to have this test could you then not say 'I'll send it off to somewhere'?

GS:
Public Health England does a lot of these esoteric tests. So for example they run Ebola, for decades unavailable, at a PHE lab. I can't see it being profitable in a private provider because it is inconvenient, it's low volume so it can be the middle of the night, it could be a Saturday 2am in the morning. I can't see any profit.

RL: Why don't they just charge more for it?

GS: But then who will pay for it?

RL:
We'd have to do look at the contract wouldn't we? The contract would list all the tests that they are contracted to do, there would be price list. If anything it's made the pricing more transparent because previously the costs of the tests were wrapped up in a global sum and no one could ever tell us how much a test was. Was it 35 pence or 35 quid?

FW:
I think the issue with tests like Ebola is that they are of a particular category so you have to maintain the facility, which are quite expensive. You don't want to have a category in which you are doing Ebola testing if it breaks out in the centre of a London hospital; you have to have very high containment. That needs to be maintained all the time, that's the problem, that's why it's costly. It's not buying the kit that does Ebola, it's maintaining that level of skills and equipment.

AB: The health service has to pick up the more expensive stuff.

FW:
For example, the microbiology staff at St Thomas's are concerned as to whether they have the capacity to perform TB testing. Is their containment facility adequate for TB tests? They say it's not.

GS: And it's expensive to maintain.

RL: Time's up I'm afraid. Thank you very much.