Keogh report: the focus on patients is essential

Sir,

Further to the editorial on the Keogh review (vol 74(8), 2013, p. 426), we feel that one of the key areas that has contributed to the failures outlined by Keogh is the lack of medical and clinical leadership on NHS trust boards and foundation hospitals. The non-executive appointments have focused on getting a diverse range of directors with experience of accountancy, law and commercial backgrounds with marketing and business sense, but there has been no requirement for boards to have clinical expertise in the form of doctors, nurses and allied health professionals.

It is important that the NHS and foundation trusts tap into the wide resource of hospital doctors available to sit on these boards, building up their capacity and using their skills to offer a knowledgeable challenge to be able to improve patient care. As Keogh pointed out: 'we found a deficit in the high level skills and sophisticated capabilities necessary at board level to draw insight from available clinical data and then use it to drive continuous improvement'.

The other key area for development in our view is that there ought to be better focus on the handling of complaints by these hospitals and to foster a culture of being open, transparent and learning from complaints and then sharing the lessons learned via established mechanisms devised for this purpose. Developing clinical leaders in the NHS is an important step and way forward in improving patient care and ensuring that patient safety always is always top and first priority.

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Sir,

In their editorial on the Keogh review Professor Singh and colleagues are absolutely right to highlight the importance of patient and public engagement and the cultural change that is needed to support it. The perplexing question is why engagement has been so half-hearted and sporadic up to now, in spite of sustained rhetoric in support of it for 20 years or more. I suggest that there are several possible reasons for this.

First, patient and public engagement has always been seen as an add-on, not as a core component of achieving a safe and high quality service. There has been a sense of noblesse oblige, with those who hold power dispensing small concessions to allow patients and the public to become involved on a strictly limited basis.

Second, patient expertise has never been valued on a par with clinical or managerial expertise, although it has become increasingly evident that each of these types of expertise is essential.

Third, ideological factors, such as the promotion of 'patient choice' over 'patient voice', have been a distraction, not least since most patients (and particularly the most vulnerable, such as frail older people) have limited opportunities to exercise choice.

Fourth, the infrastructure to support patient and public engagement has been systematically demolished and destabilised ever since the irrational abolition of Community Health Councils in 2003. The swift rise and fall of their successor bodies (Patient and Public Involvement Forums and then Local Involvement Networks) is a testament to the lack of investment in and support for patient and public engagement. The jury is out as to whether Healthwatch England and local Healthwatch will fare any better.

Finally, it would be good to see a restoration of balance on the boards of NHS organizations. The replacement of people with community knowledge by business and financial experts has clearly not achieved its desired aim in terms of avoiding the problems that Sir Bruce Keogh observed.

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Sir,

There has been significant emphasis on the role that non-executives played on trust boards in failing hospitals. Poorly performing organizations have shown that skills on those boards have not been commensurate with enhancing leadership and guidance that should have been exercised.

The Appointments Commission had a major role to play in identifying the correct people to take these appointments. It is true that they have been advertised in the national press, but there have been many instances which may be a remnant from before the Appointments Commission Board formation when appointments were often made through 'the old boy network'.

Just because one has been successful in business does not mean that one is suitable to sit on a trust board. Keogh points out the need for strong clinical competence and knowledge brought to the board room – it is important that, with the appointments function transferred to the NHS Trust Development Authority and individual foundation trusts, these recommendations are implemented. There is a wide range of excellent courses available to non-executive directors, so it should not be impossible to get the right leadership and business skills on a trust board. Maybe the missing link is the lack of understanding of the patient product. If failing trusts are going to improve their boards and delivery of care to patients, then they should pay serious attention to the configuration of the trust board, ensuring that there is an agenda item on patient care. Health and safety is a routine item on most company agendas and vast improvements have been made in this area. A patient-focused agenda could be the way forward.

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Prophylactic mastectomy and breast cancer

Sir,

I was very interested to read Mr Basu and colleagues' paper on mastectomies of healthy contralateral breasts in patients with breast cancer (vol 74(9), 2013, p. 486). What they fail to cite is the risks that these patients face. This is where the anxiety and requests for surgery arises.

The title of the article is pejorative. In current practice the surgery they are describ-