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-

ing is referred to as 'prophylactic mastectomy' because it reduces the risk of contralateral breast cancer (by approximately 95%). Basu and colleagues have chosen to refer to this as 'mastectomies of healthy breasts'.

The usually quoted lifetime risk of contralateral breast cancer in patients without high risk family history is between 20 and 25%. This compares with a lifetime risk of a first breast cancer of approximately 1 in 8 in the UK.

In the key publication referred to in the article (Early Breast Cancer Trialists' Collaborative Group, 2005), the annual contralateral breast cancer rates were in the order of 2% after polychemotherapy and 0.4%/year after tamoxifen. The tamoxifen data are often used as evidence of a very low risk when prophylactic surgery is discussed and it sounds reassuring if you are a 30-year-old who has had breast cancer, by the time you are 65 years old you will have had a cumulative risk of 14% at least if you have oestrogen receptor-positive breast cancer and you take tamoxifen. If you have a tumour that is not oestrogen receptor-positive your annual risk after chemotherapy is 2% so that by 65 years of age the cumulative risk may be 70%.

In the Early Breast Cancer Trialists' Collaborative Group (2005), the number of contralateral breast cancers actually seen over a median follow-up of just 15 years in patients under 50 years of age who had chemotherapy (including oestrogen receptor- and progesterone receptor-positive disease) was 14%.

For a young patient an annual risk of recurrence of 2% is not trivial as they have a lifetime of cumulative risk ahead of them.

Prophylactic mastectomy is appropriate for some well-informed patients, but there are concerns about finance and capacity. It is not constructive to patronise or use pejorative language. What is required is greater focus on alternative preventative strategies, sensible access to better screening techniques such as magnetic resonance imaging and a discussion with commissioners on how we make sensible management choices available to informed patients at risk.

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Early Breast Cancer Trialists' Collaborative Group (EBCTCG) (2005). Effectiveness of chemotherapy and hormonal therapy for early breast cancer on recurrence and 15 year survival: an overview of the randomised trials. *Lancet* **365**: 1687–717

Sir,

We would agree with Dr Joffe's comment that prophylactic (risk-reducing) mastectomy is entirely appropriate for some well-informed patients. The difficult question is: what level of risk of contralateral cancer do we quote?

In our own discussions with patients we use an annual cumulative risk of 0.5% per annum as the baseline risk for those with oestrogen receptor-negative disease, and 0.25% per annum for those with oestrogen receptor-positive disease on tamoxifen or an aromatase inhibitor. This is because we believe the 2% per annum quoted figure to be an overestimate, as we think it includes local recurrence as well as contralateral primary disease. Many well-informed women will indeed choose risk-reducing contralateral mastectomy based on those baseline 0.5% and 0.25% odds, especially if there is an additional risk factor such as family history or lobular cancer.

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Privatization of medical training: the shape of things to come

Sir,

The government, faced with a debt-ridden NHS, has long been outsourcing services to private companies. Despite the fact that they continue to maintain a motto of 'free at the point of delivery', the sad fact is that current changes are disturbing its foundations.

Across the UK, medical students are facing tougher capital costs than ever. With a rise in tuition fees, now £9000 per annum, many a high school leaver who is keen on medical practice is forced to look at alternative options. Despite these concerns, the UK's first private medical school has recently been established at the University of Buckingham, with fees totalling £35 000 a year. As a medical educator, I am concerned by the likely discrepancy that this will cause in terms of training delivery. Many medical schools, like the NHS, are faced with financial problems. Despite this, they strive hard to provide appropriate training to ensure their graduates will be safe and effective working doctors.

With privatization of medical training, there will no doubt be a difference in training standards, with such an establishment being able to afford, for example, more research advances or the latest technologies designed to supplement learning, technologies such as mannequin or virtual patient simulation which are not always common place at all schools. If other students are then disadvantaged as a result this may impact not only on their career progression, despite being equally capable, but also on patient care in the future.

As doctors we all need to see the potential harm that privatization may cause and instead of giving the green light to such ventures, be quick to pull the plug on the grave disparities that will result.

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