Effecting change in the NHS

Sir,

Dr Neville Goodman (vol 65(6), 2004, p. 375) highlights the dilemma of pursuing rational planning in a politically-managed public service. The dilemma is not new but it is now fully exposed as a result of consumerism flowing from the government's policies.

For many of the public, particularly older people who remember the early days of the welfare state, public buildings like hospitals are a manifestation of the reason they pay taxes. Also, the NHS is now the major employer in most parts of the country. So we should not be surprised when politicians demand no change to their local public services.

NHS managers and clinicians need to be more sophisticated to win the important argument about the need for change. They need to move away from talk of rationalizing buildings to proposing new centres of clinical quality at the same time as maintaining local access to services by, among other things, primary care-based walk-in centres providing diagnostics, simple treatment and outpatients.

People will travel to tertiary centres of excellence but many younger families are not interested in political history and would prefer to obtain routine NHS services in the same way as they obtain other services in their busy lives – on a high street, self-care 'one stop' basis. Whether that's provided by the state or independent sector is irrelevant as long as the quality is regulated.

We have to recognize that the NHS is now a consumer-driven business. It is right to secure the changes and improvements Dr Goodman is advocating but they will only be achieved if the NHS adopts a more sophisticated and proactive medico-managerial approach to managing change.

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Sir,

Dr Neville Goodman's rueful article 'Only in my back yard' deserves comment from a retired consultant physician forced into politics by an inappropriate hospital reconfiguration, which was described by Andy Black (2004) as the Kidderminster debacle.

It is a widely held but incorrect belief that the contested hospital changes in Worcestershire inevitably place every hospital reconfiguration in the political arena. The Kidderminster debacle followed unanimous rejection by local people of the wrong decision taken by the wrong people for the wrong reasons. These reasons were never fully disclosed at the time but obfuscated by spin.

Ordinary people, the users and paymasters of the NHS, are intelligent, rational beings who will accept the need to travel for elective hospital treatment and for treatment of complex, major emergencies. Indeed they will choose to go to the best hospital for treatment of rare cancers and other complex conditions. But they will not accept inequity if neighbouring communities benefit from their losses. Neither will they accept the loss of accident and emergency services if not replaced by at least realistic, doctor-led, local emergency reception and assessment facilities.

Andy Black hits the nail on the head: 'If the price of moving the complex emergency to an appropriate centre of expertise is that it is accompanied by another nine or 10 patients who are not complex acute cases then another set of problems is launched'.

If reconfiguration decisions are open, fair, appropriate and implementable, and discussed fully by locally respected clinicians with politicians and other patients' representatives then I believe there would be no need for political intervention.

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Black A (2004) Reconfiguration of surgical, emergency, and trauma services in the United Kingdom. *BMJ* **328:** 178–9

Sir,

Neville Goodman has identified the main impediment to sensible progress in the NHS. It is not the European Working Time Directive, it is not the new consultant contract, it is not even lack of funding: it is unrealistic public expectations (for which we are all partially responsible) plus our politicians' need to be re-elected.

This is not only relevant to Bristol but is a country-wide problem. In my own home city of Glasgow, for a population of roughly 700 000, we still have five acute emergency on-call hospitals, three obstetric units plus regional neurosurgical and paediatric centres. As in Bristol, debate has not concentrated on factual evidence but has been media hyped and emotion based, with everyone wanting 'their' own hospital.

To appease public sensitivities and keep all the hospitals 'open' we are to have two very expensive ambulatory care and diagnostic centres (i.e. big day units) on sites remote from the remaining hospitals which will provide full 24-hour cover – and we are trying to cut down the number of transfers! We do not need, nor can we staff three maternity hospitals but we have gone through a most emotional fracas about which one to close, and the outcome is still dependent on political approval. With elections looming, and politicians human like the rest of us, how objective can that decision be?

Local medical prejudices have not been particularly helpful and, with threats of dying babies in the press, the population is totally confused as to the real reasons and motivation for rationalization and really wants everything to stay as it was. As Goodman correctly points out, this 'just isn't possible'.

Some responsible politician or party has got to grasp this formidable nettle and explain to the public, particularly with regards to emergency medical care, that if they wish to be treated in well-staffed hospitals of the highest standard, distance will need to be traded for quality.

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