TALKING POINT

“Hamstrung by their own enthusiasm”: a cautionary tale from Milton Keynes

NEIL WATSON

The Milton Keynes District General Hospital opened in April 1984. The new city had waited for years for this essential facility. Before its opening patients requiring hospital consultations or treatment travelled either about 17 miles south to Stoke Mandeville or a similar distance north to Northampton. Ever increasing waiting times in these two places, however, led many general practitioners to refer their patients further afield, mainly to Oxford or London. The position was unacceptable for patients and their relatives and friends; the opening was eagerly awaited by the population.

Before the opening of the hospital hundreds of patients, already on waiting lists for admission to either Stoke Mandeville or Northampton, were reviewed by the consultants in Milton Keynes and, where appropriate, their names transferred to await admission in the new hospital. So, although the hospital did not start with a clean slate, within a few months of opening the hospital was running at full stretch. Indeed, the efficiency of the hospital, as judged by admission numbers and average length of stay, was as high and probably higher than anywhere else in the country. Waiting times for appointments and for admission were generally well below average. The Oxford Regional Health Authority, in whose domain Milton Keynes lies, admitted from the outset that the hospital was large enough, staffed, funded, and equipped to cope with only two thirds of the catchment population. And the population is increasing at the rate of 8000 a year, a growth rate predicted to continue for about a further 10 years. The staff of the hospital were therefore treating far more patients per head than the national averages.

Towards the end of 1984 the continued high and efficient use of the plant, aided by computerised booking and information systems, began to take its toll. Nursing and other staff, whose low establishments were presumably defined by “guesstimates,” since it was a green field site and there was no previous work pattern, began to wilt. Sickness and absenteeism started to exceed the national average, reaching 20% for a short period in early January. This was not the result of any epidemic. Stress was accepted as being a major contributory factor. During this same period, despite some “extra” moneys injected by the regional authority, it became obvious that the budget both for 1984-5 and for 1985-6 would be greatly exceeded. The initial budget was clearly inadequate; the overspending related largely to the volume of work and not to extravagance. Many items of equipment that would normally form part of a district general hospital have not yet been purchased.

Beds have already had to be temporarily closed because of a nursing shortage. Some patients have had to be diverted to

Stoke Mandeville and Northampton, even injured children. Paediatric orthopaedics was suspended for six weeks. For all the consultant staff this has become demoralising, to say the least. A uniquely young, full time, hard working, highly motivated and even pioneering group of consultants, largely unsupported by the conventional infrastructure of senior registrars and registrars, has been forced to ease off because they are too efficient.

Urgent injection of money needed

The unique opportunity that this showpiece hospital has in this upward moving and exciting city to show how the National Health Service can function at its best will evaporate fast unless there is an urgent injection of money into staff and non-staff budgets. With unemployment at its current level it seems a sad paradox.

The responsibility for this state of affairs cannot be laid at the feet of the local district administration or of the regional administration, both of whom, in this region and elsewhere, come in for much criticism. Obviously there have been planning errors, not least in overall budgeting and staffing, but I suspect that there always are in a project of this size. No, the major difficulty seems to be the central allocation of resources from the Department of Health and Social Security. As a result of the Resource Allocation Working Party some years ago the Oxford region, previously at the top, now sits at the bottom of the table so far as allocation of resources per head of population is concerned.¹ In recent years several hospitals in the Oxford region have topped the national league of efficiency. Milton Keynes is poised to join them. The region has the fastest expanding population, not least because of Milton Keynes. The DHSS has recognised this, to some extent, in its allocation of “growth” moneys. The problems in Milton Keynes, however, and in other parts of the region show no signs of an early solution.

It is naive to imagine that the many problems of the NHS, which still does so many things so well in comparison to other Western countries, can simply be solved by pouring in money. Even so, Britain is well down the European list in terms of percentage of gross national product spent on health. The recent announcement of more money for the NHS is encouraging, but past experience has shown that much of this is likely to be consumed by increases in wages and salaries, which form such a large part of the NHS budget.² The NHS needs little, if any, extra money. What it does need, and it needs it now, is a mechanism by which such money as is apportioned to health care, and more particularly hospital care, is more fairly and rationally distributed. Those hospitals that can show the most effective use of scarce resources surely merit special attention. We are, let us face it, competing for resources; why not acknowledge efficiency and effectiveness as a major factor in resource allocation. The grossly inadequate allocation to the highly efficient Oxford region is an example of the insensitive, obscure, and outdated formula that the DHSS

applies to divide up its cake. The definition and assessment of efficiency and effectiveness in hospital care is difficult, but not impossible.

Need for rationing

Hospital doctors face an increasingly difficult series of decisions in which they are required to decide on priorities in management. Some of these have been highlighted recently.³ They will have to contend with these decisions for the rest of their professional lives, for there is no conceivable way in which this country, or any other, can afford limitless "high tech" medicine. Indeed, as the "high tech" continues to develop, and the ability to sustain life, in whatever form, increases, the number of such decisions would seem likely, if anything, to increase. Some form of rationing will be necessary for the foreseeable future. This responsibility must not be shirked by the profession and many of the decisions will have to be taken at local level, for that is where the final subdivision of the cake slices takes place.

For now even more pressing decisions must be made. In a way they may at first seem simple, but in practice they do not work out that way. In surgery there are operations which, by any standard, can be considered to be cost effective. In the specialty of orthopaedics hip replacement would be a good example. In most centres the complication rate is less than 5%; the benefits to the patient, in terms of pain relief and thus reduced drug requirements, increased mobility, and less dependency on other people are enormous. A case for more facilities nationally for this type of surgery was made in the Duthie report on orthopaedic waiting lists, but no significant action has been taken.⁴ In another part of the Oxford region general practitioners are referring their patients for hip replacement elsewhere, with letters of referral containing such statements as "there is no prospect of this patient being admitted locally for this operation in the foreseeable future." In these circumstances it will be clear that the NHS, sadly, is failing, and there can be no doubt that, in many areas, elective orthopaedic admissions are curtailed for substantial parts of the year because of inadequate facilities. The allocation of resources for orthopaedics in the new hospital in Milton Keynes is insufficient, and so we are now appended to the list of hospitals in which such curtailment has become necessary. Meanwhile many expensive and relatively untried procedures continue.

Surely, at the very least, we should be able to offer patients with arthritis the benefit of such surgery without sentencing them to years of painful waiting? The increasing length of hospital waiting lists is not, unfortunately, a major political issue, but it should be made so. If money is being wasted in many parts of the NHS, despite recent efficiency drives, perhaps the implementation of the Griffiths proposals, with the appearance of district managers, offers some hope. But doctors generally are suspicious of management. Some, I suspect, fear accountability, for they are largely the instigators of expenditure. It is the doctors who require better self management.

The circumstances in which the consultant staff of the fine new hospital in Milton Keynes now find themselves are special, but not unique. They seek to provide an efficient service at district general hospital level. The recent decision to close some of its already inadequate number of beds is tragic, even though, I hope, it is temporary. What is so depressing is that a bunch of broad minded, new era enthusiasts are hamstrung by their own enthusiasm. The recent decision by the Lambeth and Southwark District Health Authority to restrict cardiothoracic surgery at Guy's Hospital comes after three years of asking the surgeons to ease off.⁵ Perhaps these are truly symptoms of the serious disease that is endemic in large bureaucratic organisations—namely, that enthusiasm, change, and efficiency are not desirable attributes. It is a disease that this country needs to eradicate in order to prepare itself for a happier, healthier, more purposeful, and more prosperous future.

"Be enthusiastic; it is contagious." A fine notion indeed. What a pity that in our sad state of affairs we find that enthusiasm, efficiency, and a voracious appetite for hard work are not assets, even in the care of the sick and in the relief of suffering, within the existing structure of the NHS. This state of affairs cannot be allowed to continue a moment longer. To start with let us rape RAWP.

References

- 1 Department of Health and Social Security. *Sharing resources for health in England: report of the resource allocation working party*. London: HMSO, 1976.
- 2 Her Majesty's Treasury. *The government's expenditure plans 1985-86 to 1987-88*. London: HMSO, 1985. (Cmnd 9428.)
- 3 Anonymous. Withdrawal of dialysis treatment. *Br Med J* 1985; **290**:249.
- 4 Department of Health and Social Security. *Orthopaedic services: waiting time for out-patient appointments and in-patient treatment*. London: HMSO, 1981. (Duthie report.)
- 5 Fletcher D. Open heart surgery halted at Guy's. *Daily Telegraph* 1985 February 26: 1 (col 4).

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Consultants and GPs in general management

Proposals for interim arrangements for consultants and general practitioners to serve as general managers and unit medical representatives under the Griffiths management proposals were published in October 1984 (13 October, p 1014). The Department of Health and Social Security has now issued a circular confirming these arrangements.¹

The circular provides for authorities where appropriate to determine general management functions for clinicians acting as unit medical representatives, on the basis of written job descriptions drawn up in agreement with the doctor concerned, and to make payments accordingly. It amends the terms and conditions of service regarding additional sessions.

The circular advises that authorities contemplating the appointment of clinicians other than consultants or general practitioners should contact the Department for guidance. Interim

arrangements for community physicians acting as general managers were also published last year and the Central Committee for Community Medicine and Community Health had hoped that a joint circular would be issued.

Reference

- 1 Department of Health and Social Security. *Health services management. Consultants and general practitioners in general management. Unit medical representatives with general management duties*. London: DHSS, 1985. (HC(85)9.)

NHS advertisements to be rationalised

The health service spends over £10m a year on advertising for staff and the government has now asked health authorities to review their advertising policy in an attempt to save £4m a year. In April 1984 the government published

a report of a scrutiny of NHS expenditure on recruitment advertising.¹ The Rayner scrutiny proposed three options—the establishment of jobs registers, the creation of two new journals to carry all recruitment advertising other than medical and dental, or the continuation of the present arrangements on a more economical basis.

After consultations with publishers and advertising agencies the government has now issued a circular favouring the third option with effect from 1 April for a trial period of two years. If anticipated savings have not been secured at the end of this time further consideration will be given to the establishment of jobs registers. Authorities should advertise in only one journal, except for consultant posts, and except where a substantial number of posts are being advertised the advertisements should be restricted to semidisplay or lineage format. Phrases such as "an interesting and challenging post" should be omitted.

The circular states that the Department of Health and Social Security will monitor the

"health" journals throughout the trial period to see that advertisements comply with the requirements and will pursue with health authorities any apparent divergencies.

¹ Department of Health and Social Security. *NHS scrutiny programme 1983. Recruitment advertising*. London: DHSS, 1984.

Limited list: BMA and ministers discuss appeal scheme

The chairman of the General Medical Services Committee met the Secretary of State on 14 March to discuss an appeal mechanism that would allow drugs on the blacklist to be prescribed in particular circumstances. The meeting arose from an invitation extended in the House of Commons by Mr Norman Fowler to which Dr Michael Wilson replied with an urgent letter on 14 March. In that letter he set out proposals that he suggested should be discussed. Apart from the appeal mechanism he has asked that the regulations should provide for a procedure whereby an interested party should be able to apply for a blacklisted drug to be removed from the list and that the list should be reformulated so that it was readily apparent on what grounds a drug had been included on the list. Because these proposals required detailed discussion Dr Wilson has suggested that the implementation of the regulations should be deferred until 1 June.

Dr Wilson's letter is reproduced here:

"I was surprised to read in yesterday's newspaper about the invitation which you extended in the House of Commons yesterday to the BMA to come to see you to discuss 'an appeal mechanism' which would enable blacklisted drugs to be prescribed in particular circumstances or would otherwise secure that all clinical requirements of all individual patients would be met. It is most unfortunate that this invitation should be issued at this very late stage.

"It is true to say that in the early consulta-

tions there were some general references by the minister or officials to an appeal procedure. It was not clear whether what was contemplated was an appeal against the inclusion of drugs on the list, rather than a procedure allowing prescription of particular drugs in particular cases. But in any event that door was firmly closed by Mr Pilling's letter of 4 February 1985, in which he said: 'From 1 April general practitioners will not be able to issue NHS scripts for any listed drug under any circumstances. To do so will be a breach of their terms of service.'

"Your invitation in the House was the first indication which we have had that the government was prepared to consider such a mechanism at this stage. It is also, I think, a pity that the invitation was not made to the GMSC or the BMA at the same time as it was announced in the House.

"Nevertheless, despite the lateness of the invitation, the GMSC is very willing to respond to it. A mechanism whereby general practitioners are enabled in special circumstances to prescribe a blacklisted drug, thereby overriding in such circumstances only the absolute compulsory nature of the list, would go some way to meet the most acute of the GMSC's objections to the present list. I set out below the detailed proposals which the GMSC are prepared to put to you for this purpose. We have, as you will know, already requested an urgent meeting, and we hope that this will be forthcoming.

"However, it is right that you should be aware at this stage of the GMSC view of the legal position. We are advised that the present regulations are unlawful. They do not comply with the requirements stated by the European Court in the Duphar decision, in the following respects:

"(a) The list is wholly inflexible. The regulations provide for no machinery whereby a drug can be removed from the list if *either* it has been included in error *or* circumstances change—for example, by reduction of price—so that the criteria which caused it to be included no longer apply. Nor do they provide for any machinery whereby general practitioners who believe that the prescription of a blacklisted drug is necessary in the circumstances of a particular case may prescribe it without penalty.

"(b) The criteria apparently used in the compilation of the list are nowhere stated in the regulations. It is true that criteria have been stated in correspondence and a parliamentary written answer, but they have no legal force and no duty is imposed on the Secretary of State to compile or maintain the list in accordance with those criteria. The ordering of the list as a simple alphabetical list of 1800 drugs makes it impossible to know what criteria have been applied in each case. Accordingly, the list does not begin to meet the requirement of verifiability.

"(c) Such criteria as have been stated are in any event too imprecise to be regarded as either objective or verifiable. There is no definition of the cost criteria—you will be aware that costs of drugs are by no means fixed or, in any event, available to the public—nor of the criteria by which drugs have been held to be 'borderline substances.'

"In the view of the GMSC, the fact that in very many circumstances, each of which may be vital to the physical and mental wellbeing of the patient, patients will be unable to receive from the NHS such drugs as his doctor regards as necessary for his proper treatment,

Chairman of the GMSC, Dr Michael Wilson.

represents a breach of the Secretary of State's statutory duty to provide a comprehensive National Health Service. The position is all the more acute for patients whose existing medication will have to be stopped.

"In these circumstances it was the intention of the GMSC, as forewarned to you by our solicitors' letters of 11 January and 24 January 1985, to apply forthwith to the court for leave to apply for judicial review and, in particular, for a declaration that the regulations are unlawful, with a view, if possible, to a substantive hearing taking place before 1 April 1985. In the light of your invitation to discussions we are prepared to defer making that application for the time being. But it is only right that we make clear that unless a compromise can be reached along the lines which we outline below, it remains our intention to pursue an application to the court.

"Our proposals are as follows:

"(1) The regulations should be amended so as to permit a general practitioner in special circumstances to prescribe a blacklisted drug. We would suggest, for your consideration, a procedure whereby a general practitioner prescribing such a drug were required to do so on a separate (perhaps differently coloured) form from the conventional FP10, so that the fact that a 'blacklist' prescription had been made was readily apparent. Family practitioner committees would still be able under their existing powers to investigate excessive prescribing. If thought necessary, under some extended powers, a subcommittee of the local medical committee could require the general practitioners to justify the prescription of the blacklisted drug. We would envisage that it would not be thought necessary for every such prescription to be challenged. But if the prescribing pattern of individual general practitioners suggested that they were regularly prescribing blacklisted drugs they would no doubt be called on to justify their behaviour, and in appropriate cases the sanctions under regulation 16 of The National Health Service (Committees and Tribunal regulations 1974) would be imposed. At present local medical committees do not generally have 'all medical' prescribing subcommittees. In our view it would be appropriate if they now did so. We would also suggest that 'special circumstances' could be defined for the purposes of paragraph 36A of the terms of service as meaning: 'those circumstances in which in the clinical judgment of the general practitioner it is necessary for the patient's health to have prescribed a drug listed in the schedule.'

Mr Norman Fowler.