Consultation re University Hospital Birmingham
(Re-formatted version of comments sent by email)

From Aaron Sloman Thu Nov 27 03:49:14 GMT 2003
To: foundation@uhb.nhs.uk
Subject: Consultation re University Hospital Birmingham

To: Mark Britnell, Chief Executive, NHS Foundation Trust Office,
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Dear Mr Britnell

I have now read the online consultation documents and have a number of comments in response to this consultation process. I am sending this in the form of a simple email text file, which I shall shortly make available on my web page, here

http://www.cs.bham.ac.uk/ axs/misc/nhs-consult

but I can easily produce a printable PDF version if required. [NOW DONE]

I write in several roles: as a patient, as a concerned citizen who lives in Selly Park, and also as someone with first hand experience of changes in management styles in large public organisations, having worked in the University system since 1962. I have been involved in developing two separate departments from nowhere to international recognition, in two different universities, as well as having a lot of contact with people in industry with whom I have collaborated. So I have some experience that's relevant to assessing the consultation document.

Mostly I am either critical or sceptical of the proposed plans and I am also seriously concerned about the nature of this 'consultation'.

1. The consultation process

As far as the nature of the consultation is concerned, I did not hear about it until very recently, and having asked around I learn that many other people who live or work in the area had not heard about it, not even our dentist – who is the best dentist we have ever had and even teaches in the University.

I would have thought that if you *really* wished to consult you'd have ensured that there were posters and leaflets at least in dentist's waiting rooms, GP's waiting rooms, waiting rooms in the hospitals concerned, and in libraries. I noticed nothing when I recently attended my GP (Selly Park Surgery), nothing at the dentist, and nothing when I had tests at Selly Park hospital. Neither was any invitation to express an opinion included with any of the letters sent to me about appointments, etc. So I presume the hospital staff are also largely unaware of what's going on.

This does not inspire confidence in the management of either the consultation process or the trust.

So, insofar as it is an attempt to find out what the community thinks, the survey process appears to be deeply flawed. Perhaps you were afraid of what you might learn?

Another thing that is totally unclear is what is going to happen to all the responses.

Who will read them? Will the responses be made accessible (anonymously obviously) so that different concerned citizens can support or criticise one another's comments?

Will an independent body read the responses and produce a public summary of how they affect the proposals?

I have seen so-called 'consultation' processes in universities which are a complete sham: responses are invited, but we never hear who has read them, whether any account was taken of them, how the objections to management proposals were answered – and then the managers do what they intended to do in any case.

Is your consultation process like that? If not, what's the difference?

2. Recent history: NHS going downhill.

My wife and I moved here from Brighton in 1991. At first we were very impressed by health services here, including the speed with which we received attention, and the general quality of service.

But in the last five or six years things generally seem to have gone downhill.

There are much longer waits, coupled with a failure to inform patients of how long their waits are likely to be – the doctor requests an appointment and then you hear nothing until shortly before the time of the appointment. So you have no way of telling whether the request has got lost, whether you will have to wait a month or a year, and so on.

This seems to be a symptom of something more general: even if the main medical staff are superb, the other people involved in making the system work leave a lot to be desired – like

- the receptionist who misinformed my wife about timing arrangements for her consultation, as a result of which she ended up seriously inconvenienced,
- the administrator who failed to pass on a letter I had written prior to a cancer consultation – it should have gone to the specialist I was to see, but was not in the file (I had guessed rightly that my doctor had forgotten to pass on some relevant information which I had mentioned at an appointment prior to the one when he decided to refer me to the specialist),
- the specialist who failed to use that information to refer me to another department after his tests had proved negative: I had to go back to my GP, who on hearing my symptoms again after the negative biopsy report, sent me to a different specialist: it is ridiculous that the cross-transfer was not done within the hospital without my having to go back to the GP. It might have been urgent. Fortunately it was not.

  I suspect the process would have been different in the days when hospitals cared about providing a service, rather than meeting government targets.
- the administrator who told me by phone that an appointment had been arranged for me at the QE hospital when in fact it was at Selly Park hospital (which I discovered by accident when I phoned back to check something).
- the doctor who refused to take seriously a complaint of a colleague from Austria, who then went back to his previous doctor in Vienna who arranged a test and found a significant allergic reaction and advised a change of environment, which removed his problem. (I keep hearing how much better other health services are than ours nowadays.)
- the treatment of a colleague whose head had been hit one night by a large rock thrown by a drunken thug – causing damage that has now rendered him permanently deaf in one ear. A policeman who quickly turned up on the scene saw that the victim badly needed

> medical attention and took him directly to hospital: clearly someone with a proper sense of service. My colleague reports that the young nurse who was supposed to be attending to him was far more concerned with chatting up the nice young policeman than finding out what was wrong and what needed to be done about it.

A more trivial indication of poor standards is the fact that one of the questions in your online form had the the wrong subject-line for its context (’Our Workforce’ instead of ‘Improving access to services’) so that people answering that question electronically will have submitted answers that are inappropriate to the subject.

Clearly someone had failed to complete a ‘copy and edit’ operation, and nobody had done the checks that would have revealed the error. This is an example of the kind of shoddiness that comes from a lack of commitment in staff. Perhaps the consultation is not being taken seriously anyway?

Staff attitudes are not something you will attend to if your main concern is to meet statistical targets and win government approval, instead of providing an outstanding service.

All of this is what I also see in universities as a result of funding cuts coupled with government specified ‘targets’ against which performance is to be assessed.

The result is that poorer quality staff are recruited, they are inadequately trained, they are overworked, and there is increasing pressure from senior management on staff to focus their energies on meeting the targets and performing well in the *assessment* exercises, rather than actually performing the *service* the nation needs them to perform.

The universities’ ‘Research Assessment Exercise’ is a well known example of this mis-directed effort and I fear something similar is happening in the NHS, a trend not identified or opposed anywhere in your document.

Perhaps if you heed these issues you will one day be able to say truly, what you already claim in the document, namely:

> *Our workforce is enthusiastic, highly skilled, compassionate and committed to caring for patients.*

That’s not what I found, overall.

3. How to reverse the deterioration, and how not to.

A radical change of culture and management attitudes is needed in order to reverse the recent trends, whether it is in schools, in hospitals, in universities, or other organisations.

Unfortunately I see nothing in your document to suggest that these issues are going to be addressed.

The problems of attitudes and training seem to me to be far more important than whether you become a foundation trust, and I see *nothing* in the document that provides any evidence that the policy of having foundation trusts is a good one.

There is a suggestion that the trust will have more freedom to raise funds.

I quote:

> *As an NHS Foundation Trust we could raise finance more quickly...*

But that begs the question of where the funds will come from and at what cost to all of us.

ANY private source of funds will regard such provision as an investment and will expect a rate of return that makes it a good investment.

Do we really want an NHS whose functions are partly skewed by the need to make investors rich?

What is your argument for the claim that that is more cost-effective than paying through the tax system so that the money comes from actual and potential beneficiaries and no third parties are made rich at the expense of everyone else, as a result?

The document, like much that I see in the public services, proposes *superficial* management changes that do not address any *real* issues and are unlikely to produce medical services that are any better (even if they produce better results according to the government's statistical tests).

4. Requirements for management

What we need instead is a management team composed of people who:

- Know how to attract and recruit the highest quality staff (and not simply relying on application forms, CVs, references and interviews to select people who will have important responsibilities for many years).

  (your document says nothing about recruitment procedures, or how you will ensure that they let in only excellent highly motivated people, unlike the ones encountered in the episodes listed above)
- Know how to train and develop staff, providing management structures that help to encourage the right attitudes and high levels of teamwork as well as developing knowledge and skills.
- Know how to use a judicious mixture of internal and independent external monitoring processes using qualitative as well as quantitative analyses, including explicit support for 'whistle-blower' mechanisms, to check up on both procedures and performance.
- Know how to tell the difference between good targets and bad targets.

  Unfortunately, from reading the consultation document I sense an obsession with rather arbitrary numerical targets.

  I quote:
  - *Reduce maximum outpatient waiting times to 4 weeks, day case waiting times to 6 weeks and inpatient waiting times to 8-10 weeks.*
  - *Reduce average maximum A&E waiting times to 2 hours or less.*

  Aiming for a uniform set of maximum waiting times ignores the fact that there are different needs, and with scarce resources it is sometimes inevitable that the only way to deal with an urgent case will push a less urgent case over the target for a maximum wait.

  I'll bet there will sometimes be pressure not to do that because of the importance of the statistical records.

  And then everyone will be treated within the required maximum, but one patient will die because he waited two weeks instead of one week, so that another patient was treated in four weeks instead of five.

  If you are going to have maxima, they should be broken down into categories of *need*, whereas what you actually use are categories of types of *provision*. That's a management-centred viewpoint, not a health-centred viewpoint.

  A medical service needs to be run by people who understand professional judgement, not by statisticians.

Then there is this piece of gobbledygook:

> *Reduce average maximum A&E waiting times to 2 hours or less.*

What is an 'average maximum' supposed to be? Maximum over what? Average maximum for every day, or for every hospital, or for each type of patient? It reads like the invention of a politician with no mathematical training. (Like 'the greatest happiness of the greatest number'.)

Whatever it is supposed to mean, the adoption of 'averages' as targets without saying anything about the *variance* is quite unacceptable.

A system that handles many thousands of people can meet targets for *average* waiting times (or average anything else) and yet allow a variance consistent with many individuals having intolerably long waiting times.

Why is this important point about averages being unsuitable targets not mentioned? Perhaps the people who wrote the objectives don't understand statistics? Or perhaps they understand but don't care, and hope the public will not understand?

Which is worse – managers who don't understand the statistical point or managers who don't care if some people have to wait 50 times longer than the average, or are treated 50 times more badly than the average?)

5. Relations with, and management of, NHS staff

Reading the document I get the impression that the main management concern is with high level formal changes which happen to fit the politics of the present government, but have nothing to do with how to produce a better health service.

The latter requires attitudes to and management of employees that produce dedicated public servants who have both the expertise and the *attitudes* that are required for a world class health service.

This requires staff to be intensely focused on the needs of patients and how to serve them and not just focused on meeting targets.

But the staff must also find the work fulfilling and have a sense of being appreciated by colleagues, patients and management.

How do you plan to achieve all that?

6. How not to motivate

I quote:

> *Ensure each member of staff has a personal development plan and the training opportunities to improve their care capabilities and fulfil their professional ambitions in line with Agenda for Change, ensuring their acquisition of further skills is matched by pay progression.*

Why shouldn't people be motivated to acquire the skills and knowledge they need independently of financial rewards?

Compare:

> 'Ah I'll go on that course and get X pounds more per month.'
>
> 'Ah I'll go on that course and learn that important new way of doing my job.'

Reading between the lines I suspect you wish to fall into the trap of following the recommendations of the government in other areas and assuming that selective financial rewards to individuals are a good means to encourage and promote the highest standards: this *completely* ignores what motivates the very best people who work in public service organisations.

Instead of helping everyone to do better, it makes people compete for rewards that only a subset will get and therefore encourages rivalry rather than teamwork, along with demoralisation among people who are not selected for financial pats on the back.

Some commercial organisations understand the importance of this point and give performance-related pay only to teams, not individuals.

Of course, having adequate levels of pay for various categories is important, but using pay differentials for micro-management is a recipe for disaster.

It's not a substitute for real management of people.

7. Rewarding and motivating staff through opportunities to contribute to management

One of the requirements for commitment and dedication is that staff *own* the high-level goals of the organisation and agree with the means chosen to achieve them.

How do you plan to encourage staff both individually and through their unions to help to formulate goals and share in management processes, so that they are committed to the institution and its objectives and always aim for the highest standards because that is what they personally want, rather than constantly worrying about how they are going to be assessed or rewarded financially?

As far as I can tell, your document nowhere mentions procedures for proper involvement of staff unions in the management.

Just having a handful of vastly outnumbered employees on boards is a form of tokenism. It ignores the fact that the people at the 'coalface' who see the real problems and opportunities, and who have the main skills on which everything else depends, are often in a better position to assess the consequences of management objectives and strategies than either patients or professional administrators or aspiring politicians.

In particular, electronic mechanisms for employee participation are now available that should be explored in order to make sure that good ideas from anywhere are given adequate consideration.

8. Excessive concern with league tables

Here are some goals from the document:

- *Open the new University Hospital Birmingham to replace QE and Selly Oak hospitals and create one of the finest healthcare environments in Europe.*
- *Further develop our tertiary care to strengthen our position as the major specialist centre for the West Midlands and ensure the highest Clinical Governance standards in all that we do.*
- *Become a major national and international research institution, firmly placing UHB as one of the top five academic clinical centres and the best clinical service delivery teaching hospital in the UK.*

Why all this concern with being *better* than others, which implies that some others, indeed many others, must be *worse* than you are?

Do you really want a health service where there is competition for status between different hospitals and health environments, instead of collaboration and a shared concern to deliver

the best health service to everyone everywhere?

If you manage to achieve your goal of being better than the others, what will you say to users of the other services?

> 'Move to Selly Oak to get good treatment?'

What's going to happen when another institution needs some help because of an emergency, and you know that if you help them that will enable them to come out better than you do in national league tables for that year?

Will you help them and then confess that you did not after all have the goal stated in the document of being '*the* major specialist centre' ?

These competitive attitudes geared to positions on ranking tables are ridiculous in a health service (or, for that matter, an education service, a fire service, a police service).

What we need is a national *integrated* service, all parts of which aim to meet the nation's needs as best they can – collaborating closely with other parts wherever necessary.

How will becoming a foundation trust contribute to that objective?

9. Involvement of the community

I quote your statement of aims:

> *Increase local ownership and direction of our services by becoming an NHS Foundation Trust. Build on our mechanisms for involving patients and the public in setting our direction and develop our services so that they are more personal, responsive and sensitive to the diverse communities we serve.*

and in another part of the document:

> *NHS Foundation Trusts will have a membership drawn from the local community.*

How are you going to get more than a tiny handful of the community involved? The same way you got people involved in responding to this consultation?

Is that really a way to produce better services or just another example of a (costly?) change in management processes that actually does nothing to improve the service provided?

> *We believe this will strengthen the connection between our hospitals and their communities, extending involvement beyond the current consultation arrangements and building on the sense of ownership that local people, patients and other stakeholders feel for the QE and Selly Oak.*

On the basis of the attempt to involve the community in this 'consultation' process I doubt that you have any realistic procedures for involving patients and the public.

Moreover, I don't see any reason why you need to be a foundation trust to achieve that.

What *exactly* will it enable you to do that you cannot do now that will make my neighbours feel they understand and approve of the organisation's objectives and strategies?

I suspect that this community involvement is simultaneously a red herring because it is not a real concern and pie in the sky because doing it properly will be very expensive and possibly make management too clumsy if done through the procedures proposed, with all the paraphernalia of elections and selection procedures.

There are better ways.

You can involve the community but this needs creative people who promote the relationship, not a change of status:

> *Having a genuine voice and influence on how the Trust and its services develop.*

Replace ‘Trust’ with ‘Hospital’ ?

> *Participating and providing regular feedback and opinions about services and possible developments.*

How are you going to pay for all this? What mechanisms will be used? Are you sure that it will be a good use of resources, and not just another talking shop dominated by people with axes to grind?

> *Receiving regular information on the Trust and healthcare in general*

Why not just make this information available to *everyone* e.g. via web sites that anyone can access? A public service should not have secret information.

> *Being consulted on plans for future development.*

I don’t believe you can do this consultation sensibly, for reasons given above.

Moreover mechanisms that rely on ‘representatives’ who attend meetings do not, in my experience, produce proper representation of views.

The representatives are usually not well-informed about the views of those they represent and do not have the means to become well-informed, unless they are high trained specialist representatives.

There are better ways of collecting opinions nowadays, including the use of new technology. But taking opinions of members of the public seriously may be a costly business. What will happen when their opinions clash with those of the management?

E.g. if the vast majority of members of the community were opposed to the proposed change of status would you then drop the proposal?

Really???

Some more of your proposed rewards for joining in:

- *Attending special functions such as open days, tours and seminars.*
- *Participating in seminars on subjects such as “wellness”, smoking cessation, heart disease and other clinical conditions.*

Again, these do not need any change of status. They are nothing new.

Moreover restricting them to members of the trust would be unfair to the rest of the community.

> *The opportunity to be elected to the Board of Governors.*

What sort of election system are you proposing? What’s to stop such elections being driven by highly active minority pressure groups who do not represent the community at large, e.g. people who don’t have the leisure time and resources to dedicate?

Access to a Members Only section on the Trusts website.

Why should there be any need for secrecy in connection with any aspect of the service?

If that is supposed to be a *reward* of some kind it's pretty crass and unimaginative.

Who is short of web sites to have access to nowadays? The internet is swimming with all sorts of opportunities to learn, play and socialise. Adding another will not provide much of a reward.

10. Local economy

I quote:

> *Help to regenerate Birmingham - by using our organisation and its resources (with an annual spend of pounds300 million and a pounds350 million new hospital project) to increase employment and prosperity in the City as a whole.*

Why do you need to be a foundation trust to do that?

You do it merely by existing and doing a good job.

11. Research

> *Develop healthcare of the future - by undertaking leading edge clinical research and by training future staff to deliver the latest advances in health care.*

What about research into preventive mechanisms and procedures? It may not be so glamorous as research leading to new drugs, equipment or surgical procedures, but perhaps it is more important – especially in connection with the increasing prevalence of obesity?

What about research on how to *really* prevent youngsters from starting to smoke?

Is enough known about the relationship between diet and various forms of cancer? Maybe knowing the answer would reduce the need to apply some of the the new forms of treatment being developed here.

12. Governing board - Public division options

> http://www.uhb.nhs.uk/about/foundation/running_02a.htm

The options presented are going to require very complex voting procedures if the elections are to ensure that all the constraints are satisfied – especially as not all the categories are mutually exclusive and therefore it's not clear whether you expect to allow one individual to fill more than one role.

Have these proposals been vetted by experts in political science and voting procedures?

It looks to me like a blue-print for a shambles, with no guarantee that the result will be selection of a collection of people who can ensure that we have a service that meets the needs of all, in a balanced way.

How on earth will the electorate know anything about the people they are voting for?

I worry particularly at the proposal to have 18 members of the public and only 4 members of hospital staff.

There are many ways of collecting information about what the public thinks on various issues, as and when necessary. That information could be presented to a group with a more even balance

between those who have to put decisions into practice and have the most expertise and those who want results but don't know enough about how to produce them.

How about

- 10 members of the public somehow selected from recent patients and close relatives of recent patients (after somehow demonstrating their ability to play a useful role)
- 12 members of staff, of whom at least 8 must be medically or technically qualified – i.e. at most 4 can be from clerical, admin, maintenance, etc. staff.

Ideally there should be a well defined set of roles that need to be filled by staff on the board: the kinds of expertise that are required and the kinds of knowledge and communicative skills.

Perhaps a selection panel (e.g. appointed by the staff unions?) could interview and assess candidates and produce summary descriptions of their abilities to fill the various roles. Those descriptions could be made available to voters along with statements from the candidates.

Then let staff members vote on the basis of information about the people they are voting for.

There should be a requirement for representatives regularly to report back to those they represent, and mechanisms for staff to request that representatives be changed if they feel they are not doing a good job.

From what I have seen of representatives on university committees, it is far too easy for the representatives to become lazy and represent only themselves or a small interest group.

13. Staffing ratios and staff representation:

I quote:

> *We employ 6,034 members of staff, of which:*
> - *10% are Medical Staff*
> - *30% are qualified Nurses*
> - *9% are auxiliary Nurses*
> - *7% are Allied Health Professionals/Pharmacists/Scientists*
> - *8% are Technical Staff*
> - *12% are Ancillary & Maintenance Staff*
> - *20% are Administrative and Clerical*
> - *4% are Managerial*

Is it really necessary to have 24% of administrative, clerical and managerial staff? Why so many?

And why are you proposing so few members of staff on the board of governors? The members of staff who have to provide the service are the ones with most knowledge of the problems, opportunities, constraints in delivering services. You need more of them.

Here are the options you've proposed for staff membership:

> *Option 1*
> *4 Governors seats*
> *All staff vote for all candidates with the top four being elected irrespective of professional background or discipline*

How will you ensure that voters have a chance to find out about the real qualities and motivation of candidates? Will candidates for election be required to provide policy statements including explanations of how they will ensure that they are kept informed of the needs and opinions of all

the staff? Will management provide resources for mechanisms by which such consultation by representatives can be supported?

Another quote from the document:

> *Option 2*
> *4 Governors seats*
> - *1 Governor will be medically qualified*
> - *1 Governor will be a registered or auxiliary nurse*
> - *1 Governor will be an AHP/Pharmacist or Scientist*
> - *1 Governor will be Ancillary, Technical, Administrative or Clerical Staff to vote only for members from their own professional group or discipline*

This has the advantage of preventing the group with largest numbers dominating the election, e.g. nurses, or admin/clerical/managerial staff!

But it's still too small a number in relation to members of the public.

14. Board of Governors - Stakeholder Governors

I note that the list of groups to be represented included here

> http://www.uhb.nhs.uk/about/foundation/running_02c.htm

does not include national or local staff unions. This, along with the proposal to restrict staff membership to only 4 makes it clear that the proposal has been drawn up by people who do not understand how to manage a large body of expert staff who need to be strongly committed to the service.

I personally have no confidence in people who produce proposals like this.

15. Comment on glossary entry

I was interested to see this in the glossary:

> **Payment by results**
> *A new system being introduced by the Department of Health to reform the way providers of health care are paid for the services they provide. In future trusts will be paid at a national tariff for each patient actually treated.*

This is a wonderful example of muddled government/managerial thinking.

This is NOT payment by results. It is payment by SERVICES PROVIDED.

RESULTS are matter of quality and effectiveness of the service.

I find this all very worrying.

It's time to start again.

Yours truly,

Aaron Sloman
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