Belt tightening is the order of the day

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Financial famine ahead

Recent weeks have seen dire warnings of 'financial famine' in the NHS at almost every meeting I have attended. The stock market seems to be picking up and house prices are reported to be rising again, but the Government has borrowed so much to prop up the banks that public services will all have to suffer for years to come, irrespective of the political rhetoric about maintaining NHS funding. We are told that the financial famine will not be immediate, because current spending allocations have been agreed and will be honoured; so the NHS will really start to feel the pinch in the next financial year, not this one. That will be at about the time when bankers start receiving large bonuses again, if current predictions are correct.

In this new financial climate I have been told that Lord Carter's report is now 'out of date'. As far as I can tell, this refers mainly to his assertion that improved efficiency could cut 10-20% of costs, and that the savings should be reinvested in the service. It's the last bit that is out of date. We are now being told we will be expected to provide the service with 20% less money. The reinvestment has evaporated.

A non-negotiable 20% cut in funding will require a reduction in staff costs. Whether that is achieved by reduced pay or reduced staff numbers is a Trade Union matter. From the perspective of the College, the options for those still in work seem to be:

1. Work harder and faster for longer, but for no more pay.
2. Do less work.
3. Do lower quality work.
4. Become more efficient without assistance from initial investment.
5. Find the resources from somewhere else to reorganise and become more efficient.

The fourth option is surely limited by the fact that we've been trying to do that for as long as I can remember. That's not to say we shouldn't try, but it won't be easy. The fifth option looks more attractive, doesn't it? But what if, as seems likely, the 'somewhere else' is the private sector? As I have repeatedly said, the College cannot express an opinion on the nature of the provider, if the quality of patient care is good; we are not a Trade Union. But worrying precedents include commercial contracts that do not include training. There are rumours of laboratory services offered as 'loss-leaders' to persuade Trusts to shut down their own laboratories. Once that's been done, one wonders what will happen when the contract has to be renegotiated.

We are in this mess because the financial system drove bankers to make foolish decisions in pursuit of short-term gains. It will be a sad parallel if the result is a health service that drives managers to make foolish decisions in pursuit of short-term economies.

Quality – what's in it for you?

Which brings me back to my words in the last President's Column: on the need for a sophisticated way to define quality in pathology services. We need a way in which purchasers and patients can know what they are getting, a way to counter those who might see high quality pathology as nothing more than generating numbers with low cost and fast turnaround. We held a meeting on clinical service accreditation on 29th June. A short report is available at www.rcpath.org/resources/pdf/accreditationmeetingreport.pdf. The outcome, for reasons given in the report, was a call for coordination of accreditation services, minimising bureaucracy by eliminating overlapping inspections and making the output of accreditation schemes more quantitative. There should be something akin to a 'quality metric' for pathology, with benchmarking against other providers, and specific reports that are relevant to the needs of individual regulators. To move this forward in relation to pathology we are now planning a pathology-specific meeting that will inform the future development of CPA accreditation. It will no doubt address the Carter criticisms and become more concerned with 'the end-to-end service'. It will, I hope, pay more attention to sustainability of the service. This is an important process for all of us.

Tasks from the Academy

On the subject of financial famine in the NHS, I have in the last month obtained two poisoned chalices from the Academy of Medical Royal Colleges. The first is membership of a working group on how the NHS should adapt to the impending cut in funding. (Answers, whether on the back of a postcard or by email, would be welcome.) I am reminded of the fate of Frank Field MP, who some years ago was asked by Tony Blair to 'think the un-

thinkable' on welfare reform. He did so, and he has been on the back benches ever since. But I thought it better to be involved in the process than to be a passive recipient of cuts devised by others.

The second, more substantial, poisoned chalice is a request to take over from Dr Judith Hulf (President of the Royal College of Anaesthetists) as Academy lead on medical revalidation. This does not put me in the driving seat, as the process is being led by the GMC; but it does put me in a better position to warn the driver about approaching trees, roadblocks and potholes. My perception so far is of a process that is getting bogged down in detail, with well-meaning individuals too far from the coalface trying to set out how each variety of medical practitioner shall demonstrate compliance with every item in the GMC's 'Good Medical Practice'. Part of the bureaucratic overload arises from the remarkable variety of medical practice. People are asking 'How will the doctor on a cruise ship revalidate?' – but one could substitute the doctor working in pharmaceutical research, the doctor who only does coroner's post-mortems, or many others. At present each new example seems to generate another ream of paper and a fusillade of bullet points. At some point we are going to have to admit that the process demands judgement by knowledgeable and trained individuals, not just slavish adherence to a huge set of tick-boxes. The potential cost is getting astronomical, and most of it seems to be heading towards the Medical Directors of NHS Trusts. A 20% cut here would be a welcome start – except that this is a budget that doesn't even exist yet. Perhaps in this case a dose of financial realism will have a beneficial effect; it's an ill wind that blows nobody any good.

From the perspective of the College, we anticipate being involved in quality control of the revalidation system, in providing advice for Responsible Officers and in resolving disagreements when a pathologist is criticised during the 'enhanced appraisal' process in a way that he/she believes is not reasonable. That will demand a good deal of training if uniform national standards are to be developed – as they surely must be. We will also be providing tools to help pathologists comply with the new requirements, whether an improved CPD system, a multi-source feedback tool or (possibly) an 'e-portfolio' to help you to gather the required evidence. The problem is that at present we don't know enough about what will be needed to offer an estimate of the cost. It won't be free. But at present, by far the largest share of the cost of revalidation will fall on NHS Trusts. In an NHS facing financial famine, I predict that they won't like it.

Human Tissue Authority

Speaking of 20% cuts, I have had a meeting with the Chair and Chief Executive of the Human Tissue Authority. Aware of the anguish caused by their eye-watering increases in licensing fees I explained the predictions for pathology funding, and suggested they should share the misery by cutting their licence fees by 20%. The response was not entirely favourable, but a price freeze was promised. I also complained that, with the resignation of Professor James Ironside, the Authority is now functioning without any members who have personal experience of working in a diagnostic laboratory or undertaking a post-mortem examination. I was informed that a review of the Authority's structure is underway, but I remain wholly dissatisfied with the lack of urgency.

But the complaints were not one-way. As we approach the tenth anniversary of the publicity storm around organ retention, it is depressing to hear that the number of non-compliances found by HTA inspectors in the post-mortem sector has apparently increased, not decreased. The sector is now regarded by the HTA as its highest risk. 'Risk', like 'quality', means different things to different people. Naturally, to the HTA, 'risk' is defined in the terms of a regulator; risk of a breach of the regulations more than risk of harming patients; but in view of the history of this subject, that's not an excuse. We will no doubt hear more. We will need to tease out the underlying reasons. If there is incompetence or indifference on the part of pathologists, that's indefensible. But the reasons will at least in part relate to communication difficulties between pathologists, mortuaries and coroners. Problems are exacerbated by the regrettable decline in interest in 'the ultimate audit' within the health service, and to the lack of a specific responsibility for coroners to consider the needs of the bereaved. The NHS currently provides all the training and most of the facilities for undertaking post-mortems, but the service is almost entirely used by the Ministry of Justice and the Home Office. Change is inevitable. We must try to ensure that it is for the better, and we are arguing for changes in the Coroners and Justice Bill as part of the solution. More on that, I suspect, in the next *Bulletin*.

International

Getting away from the woes of the UK, our International Committee seems to be getting more active by the day, presenting a number of difficult questions in relation to the use of our limited resources. Its tasks fall into two broad areas.

The first is the need for the College to satisfy the various needs of its Fellows and trainees outside the UK. That's about 20% of our membership and I believe they have been neglected in recent years. For example, there have been many complaints that our curricula and examination systems are now so geared to the UK healthcare system that they are disproportionately difficult for candidates who have not trained in the UK.

The problem is exacerbated by changes in UK immigration and work permit rules. This is, apparently, a problem that other UK Medical Royal Colleges are also facing. To develop a separate set of 'International FRCPath' examinations would be a daunting and expensive task; running examinations within the UK is already a drain on College finances, despite the large fees. Alternatives being explored include helping local organisations to establish and quality control their own systems. We also receive requests to inspect and advise on local training programmes. We have no formal authority to give or withhold approval, but we are trying to re-establish mechanisms by which we can make some sort of evaluation and give appropriate advice.

The second area is the need (as a charity) to help to improve pathology services in disadvantaged parts of the world. A discussion paper on this topic commissioned by the International Committee emphasises the magnitude of the problem, and puts our own woes into perspective. There are many factors (such as war and poverty) that are far beyond the College's control. If you are starving or being shot at, it has to be admitted that high quality pathology services are not the top priority.

Part of the problem is finding out what would be helpful; it is all too easy to provide 'help' that's not actually helpful. We are collaborating with others in projects in Africa and in Papua New Guinea. I personally believe there is scope to do more in this area at little or no cost to the College. I know that there are many Fellows – based in the UK and elsewhere -- who would be interested in sharing their expertise with those in other countries, and not just financially disadvantaged ones, if only there was better information on what is needed and what is available locally. Perhaps we can set up an 'experience exchange' section on the College website. We could invite services in need to set out what sort of help they would like, and what amenities they can offer. We could also add reports from individuals who had been to each location, as unbiased testimonials of what to expect. 'Gap-years for grown-ups', you might call it; though the time period could be anything from a few days upwards, depending on need and availability. Would this work? Would you be interested? Let me know. Especially if you are based outside the UK.

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Speak up: give your view on College consultations

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Your opinion is vital in helping us ensure that all the documents we produce are reliable and workable in practice – and what you say, counts. You can also claim up to 2 CPD credits for this work. All college documents are put for consultation on the website, you just need to login and visit www.rcpath.org/index.asp?PageID=90

Here you will find all the documents open for consultation and information on the status of documents in the process of being revised before final publication. When a new document is posted, we send out an email to the relevant members advising them of the open consultation.

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