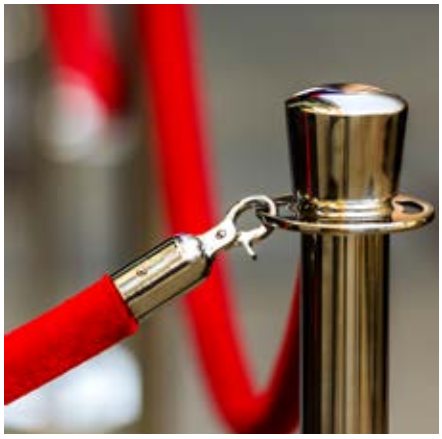
The most exclusive club in the NHS



A self selected group of 10 leading hospitals has emerged as a force to be reckoned with in England's NHS, with easy access to Whitehall. But what is its members' shared agenda—are they just fat cats skimming the cream, asks **Nigel Hawkes**

It has just 10 members, all of them leading academic hospitals with clean records and powerful chief executives, many of whom have been in office for a long time. Unsullied by the scandals that have damaged the foundation trust brand, the members of the Shelford Group see themselves as the backbone of the NHS in England: "harbours of stability" in changing times, to quote Andrew Cash, chief executive of Sheffield Teaching Hospitals NHS Foundation Trust. To anonymous critics from humbler trusts whose playground is the comments section following online articles in *Health Service Journal*, they are fat cats trading on past glories—a would-be premier league that sits at the top of the funding pyramid, has avoided the worst of the economies forced on others, and intends to maintain that privileged position by collective action.

I put the criticism to Robert Naylor, chief executive of University College London Hospitals NHS Foundation Trust and current chair of the Shelford Group. Are you fat cats monopolising the cream? "If we are we don't intend to be," he said. "We have a particular common interest as teaching hospitals and major research centres. We recognised we were in a different place to the rest of the NHS. When benchmarked against the rest of the NHS we were better than average, which is not terribly helpful as a form of benchmarking. So we decided to come together, the 10 of us, and the real purpose was to benchmark against each other."

The prime mover was Gareth Goodier, then chief executive of Cambridge University Hospitals NHS Foundation Trust, who had experience of a similar benchmarking network in his native Australia. He organised get togethers of likeminded chief executives at his home in Great Shelford, Cambridgeshire, and the group adopted the village's name. Goodier has since returned to Australia, but the name has stuck.

The group was set up as a company limited by guarantee in July 2011 under the name Shelford Health Roundtable, but this was simply to prevent anyone else using the trading name. Its accounts at Companies House are unrevealing: it is classified as a dormant company because it had no significant accounting transactions in the year to July 2013. What happens, the group explained, is that the secretariat costs are paid by the trust that holds the chair in that particular year, and when money is needed for commissioning a project, the cost is agreed and divided between the members. "It doesn't cost much" said Dame Julie Moore, chief executive of University Hospitals Birmingham NHS Foundation Trust.

"We realised that we had nearly 200 years of chief executive experience between us. That makes us attractive for key policy makers and politicians"

The 10 chief executives meet monthly, usually in the evening so as not to interrupt normal work. "When we had a farewell dinner for Gareth Goodier, we realised that we had nearly 200 years of chief executive experience between us," said Naylor. "That makes us attractive for key policy makers and politicians, and when we meet we normally have people come to see us. Last week it was Jeremy Hunt," he said.

Action on nursing

Separate meetings are held by the medical directors, the finance director, and the chief nurses from the 10 trusts, focusing on their particular areas of expertise. "Take the nurses' group as an example," said Naylor. "There's pressure in the NHS to set a nursing ratio—one nurse to every seven patients, say—but our view is that there shouldn't be such a fixed ratio. A paediatric cancer ward, for example, needs twice as many nurses as a geriatric ward. Life is not simple; you have to look at acuity [level of medical need]. You might have 30 patients on a ward, and six require one-to-one care, so you can't say you need six nurses to look after 30 patients; you need six just to look after the six."

The nurses' discussions have revived a product first created in 2007 and originally supported by the Association of UK University Hospitals, the Safer Nursing Care Tool. This is a data collection system that enables nurses to assess the acuity and dependency of patients on their wards in order to calculate the staff needed to meet patients' needs. This tool has proved very useful, according to Moore. "People have tried very many ways to work out how many nurses you need, but it has to be based on the type of patients and how dependent they are, and it varies from time to time. The acuity of patients has gone up and up; you tend to forget how different it has become."

In its response to the Francis report on Mid Staffordshire, the government held back from setting mandatory staffing levels for nurses but said that trusts must conduct six monthly reviews of staffing, to be made public and monitored by the Care Quality Commission.[1] In a letter to the *Times* newspaper published on 21 November the Shelford chief nurses group urged the use of the tool to determine what staffing levels should be.[2] The group's intervention seems to have been timely and influential.

Fight for extra money

More controversial, perhaps, has been the claim made by the group that specialist academic hospitals are disadvantaged by the tariff under which providers are paid for each episode of care. The group believes that the tariff under-rewards specialist hospitals because their patients are likely to be more ill, require more complex care, and have higher costs. In London a group of specialist trusts won the argument for a top-up payment under a scheme called Project Diamond, and NHS London handed out £40m in 2010-11 and a further £50m in 2011-12 to make up for the tariff's failure to fully account for these extra costs. Although NHS London no longer exists, payments are expected to continue through NHS England, the commissioning body for specialist care.

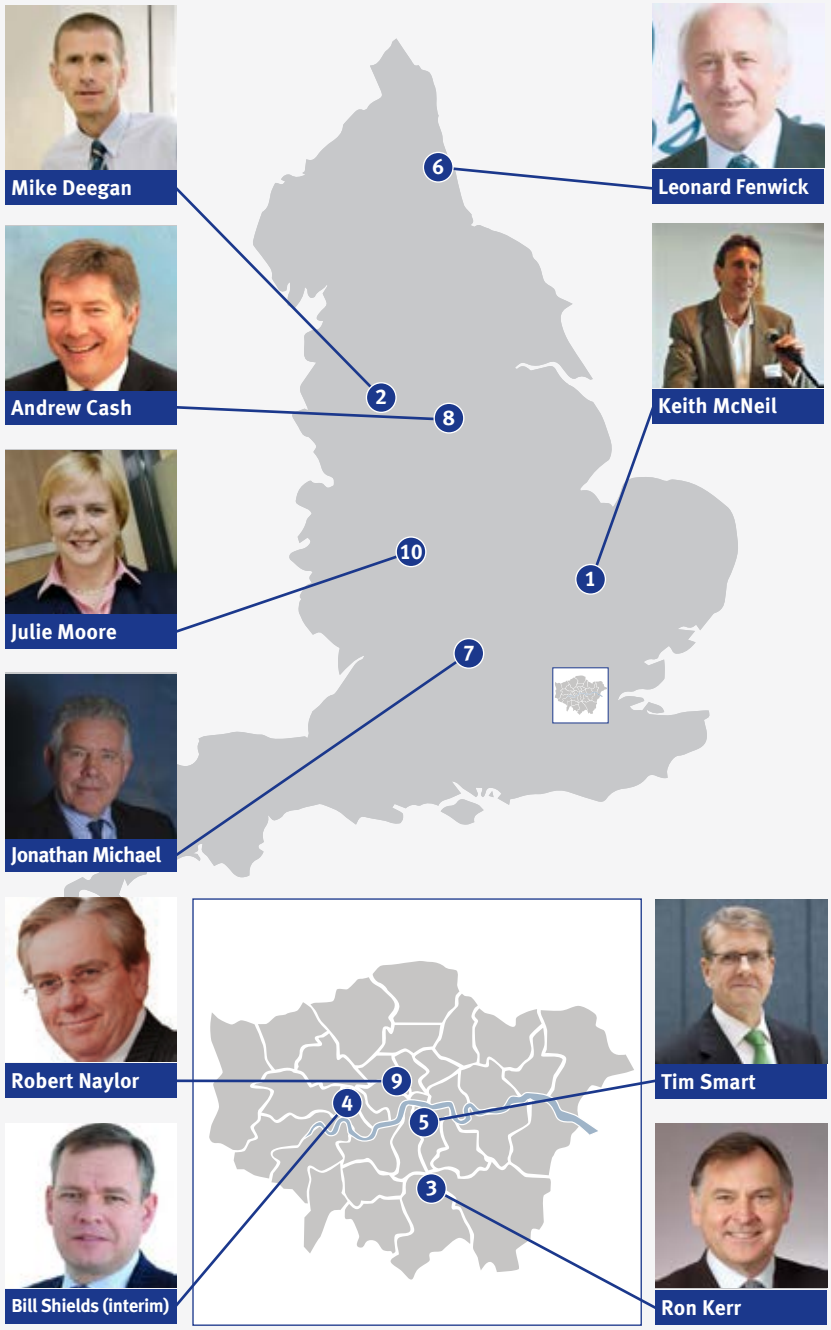
Naylor said: "Most major developed countries do the same, adding a percentage to the tariff. In the long term it should be possible to make the tariff more sophisticated, but there's no example in the world that we could find that's cracked it." He added that there was "a very strong opinion" in the Shelford Group that the London solution should also apply to hospitals outside the capital. Cash, in Sheffield, went further, arguing that the tariff problem was one of the two main reasons for setting up the group in the first place (the other being benchmarking). He cited the example of care for rectal cancer, where a study at Sheffield had found that the trust was losing 40% of the tariff price for every case it treated.

"But we did feel it was tricky making the case for extra money," he said. "It's got to be based on strong evidence rather than being caricatured as whingeing by academic hospitals. It's not big money, this, maybe £30-50m a year. We don't know how much it would be, and it has to be calculated independently. We need to look at each portfolio and write off losses against gains, and we want that independently verified by the tariff team and by outside consultants." The Shelford Group made a submission two months ago to NHS England for the extra funding, he added, and it was under consideration.

Moore agrees that an uplift is justified but seems sceptical that one will ever be granted. "Specialist hospitals don't treat typical patients," she said. "If we operate to repair a hernia, it'll be in a patient with diabetes, or a transplant recipient, or whatever. We're a trust of last resort. The tariff is quite crude—in most other places in the world specialist hospitals receive extra resources. They get it in London but the rest of us are struggling on. We need a Project Diamond outside London." Are you getting anywhere with it? "No, we're not getting anywhere with it, and I don't think we will."

The group has lobbied hard for the extra cash ever since its inception—a letter to the *Financial Times* in late 2011signed by the 10 chief executives and claiming the tariff shortfall would be £400m that year was one of the first times the group put its head above the parapet.[3] At the time, the group was lobbying the Department of Health and the Treasury along the same lines. In a pitch calculated to appeal to the Treasury, the group argued that the shortfall in funding could lead to clinical trials in the UK drying up, with "long-reaching implications for employment, exports and the economy."

The argument hasn't gone uncontested. Critics point out that specialist hospitals actually earn a far lower proportion of their income from the tariff than do other trusts, with a much higher proportion coming from off-tariff specialist contracts.



THE SHELFORD GROUP

Members' annual turnover:

1) Cambridge University Hospitals NHS Foundation Trust (chief executive Keith McNeil): £661m
2) Central Manchester University Hospitals NHS Foundation Trust (Mike Deegan): £850m
3) Guy's and St Thomas' NHS Foundation Trust (Ron Kerr): £1.1bn
4) Imperial College Healthcare NHS Trust (Bill Shields - interim): £900m
5)King's College London Hospital NHS Foundation Trust (Tim Smart): £630m
6) Newcastle upon Tyne Hospitals NHS Foundation Trust (Leonard Fenwick): £850m
7) Oxford University Hospitals NHS Trust (Jonathan Michael): £788m
8) Sheffield Teaching Hospitals NHS Foundation Trust (Andrew Cash): £909m
9) University College Hospital NHS Foundation Trust (Robert Naylor): £738m
10) University Hospitals Birmingham NHS Foundation Trust (Julie Moore): $584m

Guy's and St Thomas' NHS Foundation Trust, for example, the foundation trust with the biggest income in 2010-11, earned just £196m of its total £953m from the tariff. The same applies, to a greater or lesser extent, to other members of the group. In addition, Shelford Group hospitals receive more in long stay payments under the tariff, as well as other top-ups such as the service increment for teaching (SIFT), the market forces factor (which favours London hospitals in particular), charitable contributions, and research funding.

Just elitism?

I asked Naylor what he said to critics who complained that the group represented big successful hospitals and that they didn't need any more. "You have to educate them," he replied.

But he acknowledged that the cost efficiency targets being imposed on the NHS were a bigger challenge to district general hospitals than to teaching hospitals. "They're stretched both ways. They're told to discharge patients quickly back to the community and pressed to refer specialist activity to fewer, larger places. So they're pulled in two directions. There are major financial problems there."

The 10 trusts that form the group are not the only important tertiary centres in England, so how did the membership come about? Is it an exclusive club, or can others aspire to join? Naylor said membership had been determined by a mixture of objective and subjective criteria. According to Moore, the objective element included some metrics created by Price Waterhouse Coopers, which took into account size, quality, research, and teaching. "There were several other trusts that didn't meet the metrics, so they fell out," she said. "Two of the member trusts are not foundation trusts (Oxford and Imperial), but they scored highly on quality metrics and so made up for that."

All three chief executives who spoke to me agreed that personal chemistry between the 10 had been important—"we like each other's company," said Moore. She said that the group was anxious not to duplicate the work of any other body. "There is the UK Association for University Hospitals, but it has more than 40 organisations in it—everyone teaches now—and it's a UK-wide organisation, while we're England only. And there's the Foundation Trust Network, but we're not all foundation trusts. We've had meetings with both organisations and we remain members of them, if we were before. We think 10 is about the right number for what we want to do."

Asked if there is a parallel with the Russell Group of universities, Naylor didn't dissent. "Like the Russell Group, we'll probably grow in time, but we wanted to establish ourselves first. We've had many debates about expressing our opinions publicly, and there's increasing interest in that. But we'd rather influence policy behind the scenes than through the media. People might say 'Oh, they're a self-interest group, they would say that.'"

In an NHS that is supposed to be run by general practitioners through clinical commissioning groups, the big providers getting together might be seen as a reactionary response. But whatever the theoretical source of power in the NHS, hospitals have always proved adept at pulling the strings, and none more so than the big teaching hospitals. This can get people's backs up, as the more colourful accusations hurled under the cover of anonymity in *Health Service Journal* make clear: "elitist claptrap indicating that we're most certainly not all in this together," . . . "arrogant pompous organisations," . . . "the epitome of those organisations who have attempted to grow their way out of the economic downturn creating chaos around them," to quote a few of them.

"We're a trust of last resort. The tariff is quite crude—in most other places in the world specialist hospitals receive extra resources"

Do the charges stick? As long term survivors in NHS management where the average duration of a chief executive's survival is only two years, the Shelford Group's leaders are certainly a self confident bunch but do not come across as arrogant. "We represent a very senior cadre of leaders in the NHS," said Cash. "On 1 April 2013, when the health reforms were implemented, we lost some senior people with the demise of the strategic health authorities, so the Shelford Group is seen as an alternative source. We can deliver change, but also provide calmness."

After a selection procedure, the group has contracted the market oriented think tank Reform to help project its message. Reform's director, Andrew Haldenby, said he was delighted and proud to have been chosen. The first step was to talk to all the chief executives and write a report outlining common issues; the second will be two cross-party conferences next year, the first on 14 March on the future provider landscape at which both Jeremy Hunt and his shadow, Andy Burnham, have agreed to speak.

Big ambitions

Reform's report on the group, which has yet to be discussed by its members, starts with a conclusion none of them is likely to dispute: "The Shelford Group is a unique resource that should be a valuable support for policy makers in the rest of this parliament and beyond." It identifies the subject of greatest current importance as integration of care. Here the group can compare the experience of hospitals that did and didn't take over community care under the last government's changes. In evidence to the health select committee the group showed that its members that run community care were better able to manage pressure on emergency departments. Moore singles out Newcastle upon Tyne Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust as good examples, lamenting meanwhile that her own area, Birmingham, has a fragmented system: "I'd like to see a lot more coming together of acute and community care," she said.

Nearly all the Shelford Group hospitals have grown large by merger, some by successive waves of mergers. Their size provides security. But are their territorial ambitions sated? Privately, some of the group's chief executives have been heard to argue that they could run the entire local health economy better than the present incumbents do. That's quite possibly true, but those I spoke to on the record were more circumspect, emphasising cooperation rather than takeover as the pattern for the future. "There are too many hospitals in the NHS," said Moore. "Lots are not big enough. But we don't want to lose them—it's better to keep them alive but in a different way." She suggested that combining backroom functions such as human resources and information technology could provide savings.

In London, where there is a hospital on every corner, more radical change is likely. "The NHS is in a state of disarray, uncertainty, and challenge," said Naylor, who has argued that it was a mistake to entrust GPs with commissioning and favours "end to end" healthcare for London with six to 10 providers offering a fully integrated service and patients free to choose which of the competing providers to join. But this is not Shelford Group policy—Cash said that, unlike Naylor, he supported the commissioning role of GPs and was encouraged by the reforms.

So it would be wrong to see the group as monolithic or driven by ideology. Some of its chief executives are empire builders, no doubt, but others are more tractable and cooperative. What is clear is that the NHS in England has a powerful new player whose views are already heard and are likely to become more influential with time. Safe harbours are especially attractive when the waters are choppy.

Nigel Hawkes freelance journalist, London, UK
nigel.hawkes1@btinternet.com

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On the brink of collapse

Destroyed hospitals and shortages of doctors and drugs have taken their toll on the health system after two years of civil war in Syria, and now polio has re-emerged, writes **Keir Stone-Brown**

Many have had to flee to neighbouring countries such as Lebanon or Turkey or have had to make the perilous trip to Damascus to get care

The Syrian civil war has become one of the worst humanitarian disasters of this century. According to Elizabeth Hoff, the World Health Organization's representative to Syria for the past year, it has claimed 115 000 lives and injured more than 575 000 people. And, worryingly, no end seems in sight.

"The health situation has drastically deteriorated over the past few months, with an estimated 6.5 million displaced within Syria. There are critical gaps in essential healthcare delivery," she said.

What began in March 2011 as a revolution driven by the hope of the Arab Spring, has since deteriorated into a stalemate between President Assad's regime and tentatively allied opposition forces.

As of June 2013, two in every five hospitals were out of service. Lack of power has forced many to operate in almost impossible conditions. In Homs, a city heavily affected by the conflict, only two hospitals remain open, with the major hospital, Al Watani, badly damaged.

In the Aleppo region, near the Turkish border, the situation is unsustainable, according to Omar Abdul Gabbar, a consultant orthopaedic and spinal surgeon and medical lead for the humanitarian organisation Hand in Hand for Syria. "This is a city of five million. Assuming two million have left the town and one million are in the government controlled area, you have a population of two million served by 35 surgeons to treat everything including war injuries," he said.

WHO is providing humanitarian assistance in conjunction with 36 non-governmental organisations. But their work is not straightforward. "We have difficulties in delivering supplies outside Damascus. We have had had two shipments hijacked on the way to Aleppo," said Hoff. Setbacks such as these make providing care in Syria all the harder. However, luckily in this case all was not lost. "They were used in the opposition controlled areas. The medicines were not lost; they were just diverted and still used for health purposes."

Most doctors have fled

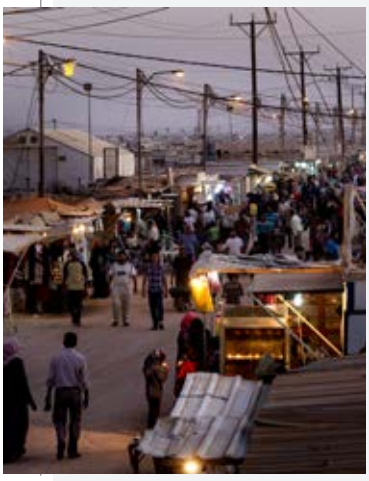
WHO estimates that some 80 000 doctors have emigrated, leaving just 37 000 in Syria. "Doctors were some of the first departures from Syria because they could afford it and they can find work elsewhere," said Hanna Kaade, a newly graduated doctor and a coordinator for the Red Crescent in Aleppo and WHO in northern Syria. "Many of the hospitals have gone out of service because they don't have the staff, have become military centres, or have just become ruins. We just don't have the ability to accept the amount of patients we need to."

With the war still raging there has not been the chance to rebuild medical centres. "There are areas where they're still under constant bombardment, constant fighting and shelling, where they have developed makeshift hospitals in underground buildings," Gabbar said.

This leaves a population struggling to receive much needed healthcare. Many have had to flee to neighbouring countries such as Lebanon or Turkey or have had to make the perilous trip to Damascus to get care. "We used to have many patients coming from all across the country. That is not the case anymore," said Khaled Alok, a medical student studying in Damascus.

Road closures, checkpoints, and the lack of public transport have changed the patient demographic, yet there are still many to treat. Healthcare workers in rural areas outside of Damascus travel for at least three hours to reach medical centres in the city, everyday running the risk of encountering snipers, road-

DOCTORS OF THE WORLD: A CHARITY HELPING TO BRING MEDICAL CARE TO NINE MILLION DISPLACED SYRIANS



"Zaatari camp is considered the fourth biggest city in Jordan," a volunteer medical coordinator who had recently been working there told the *BMJ*. Just inside the border, the camp began only a year and a half ago but has exploded to a population of well over 100 000. The charity Doctors of the World manages and staffs two medical centres in the camp.

"This situation is overwhelming," according to a volunteer pharmacist. "In the summer the biggest fear was cholera," she said. But no outbreak came. "The fear now is polio, which Jordan has not seen for many years.

"Diseases like diabetes and hypertension are quite a challenge. In an emergency context nobody thinks about non-communicable disease."

Zaatari's residents are also experiencing mental health problems: "Post-traumatic stress disorder and depression are quite common in the camp."

A doctor volunteer who'd been working with displaced people close to Syria's border with Turkey for the past 10 months told the *BMJ* that humanitarian organisations are struggling. "The biggest problem is the cold—they need blankets and more tents."

His pharmacist colleague mentioned other dangers: "People have a lot of stress. It's easy for them to use their guns."

Made up of 14 independent national organisations, the charity has 3000 volunteer workers in more than 300 programmes in 70 countries.

Recent figures suggest some nine million people are in need as a result of the fighting in Syria. Some 100 000 adults and children have died so far. Without help from organisations such as Doctors of the World the number would be likely to be far higher.

Richard Hurley deputy magazine editor, *BMJ*, London, UK **rhurley@bmj.com**

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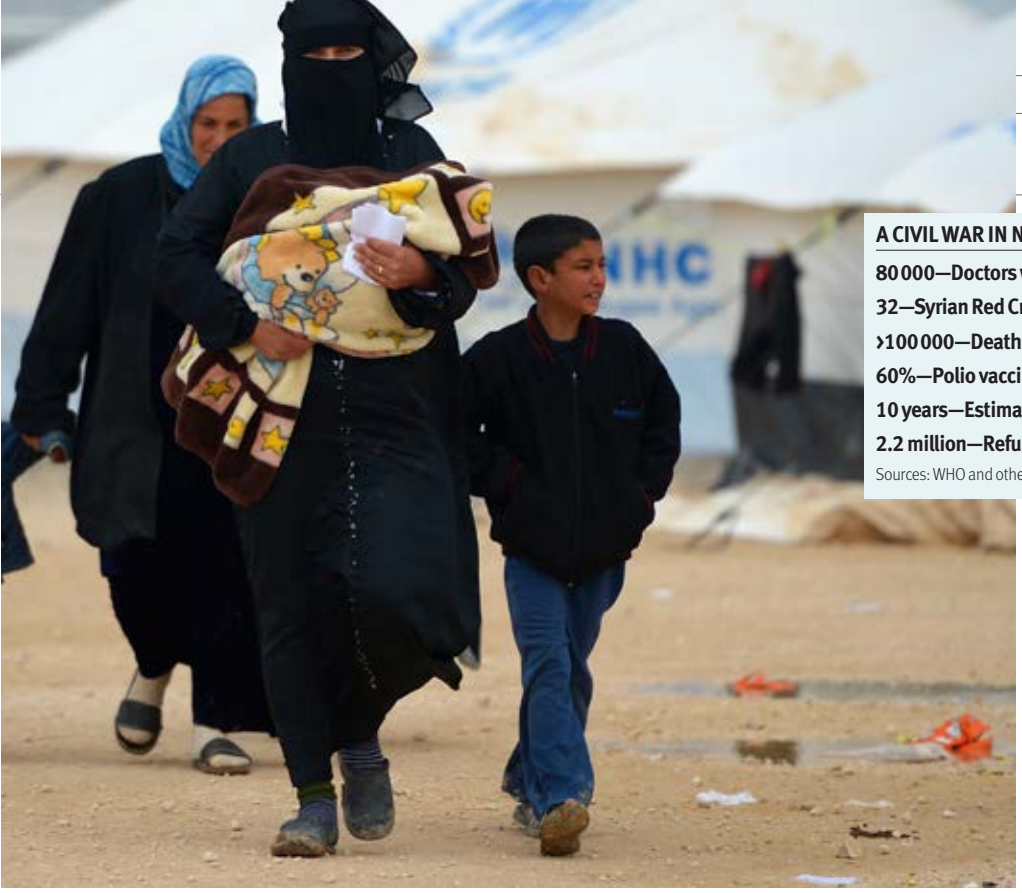

A CIVIL WAR IN NUMBERS

80 000—Doctors who have fled the conflict; 37 000 remain

32—Syrian Red Crescent medical volunteers killed in the conflict

>100 000—Deaths since the conflict began

60%—Polio vaccination rate (down from 90%)

10 years—Estimated time to rebuild facilities if the war stopped now

2.2 million—Refugees in neighbouring countries

Sources: WHO and other United Nations agencies

side explosions, and suicide bombers.

According to WHO, before the outbreak of the war, 90% of drugs in Syria were locally produced. Many pharmaceutical plants have been destroyed, which has led to a 70% fall in production.[1]

Pharmacies now try to control their stock by limiting the amount each patient can buy. As a result, many Syrians with chronic health problems have turned to the black market. Drugs are smuggled over borders and sold at inflated prices with the risk that the supply could stop any day.[1]

Return of polio

Civil war has led to a drop in vaccination rates and the re-emergence of polio, a previously eradicated disease. Hoff, who is coordinating WHO's humanitarian effort, said that there have been 22 reports of polio resulting in partial paralysis, although only 10 have been confirmed.[4]

"There has been a drop in the vaccination coverage from around 90% before the war started to around 60% to 2012," she said. The United Nations has warned that half a million children, regardless of where they live in Syria, need to be urgently vaccinated against the highly infectious disease, but access to the high risk areas is difficult.[5] WHO has vaccinated 60 000 children in a door to door campaign, and there will be subsequent vaccination programmes in Syria and neighbouring countries.

But Hoff is pessimistic: "The vaccination campaign will not be sufficient to deal with this problem . . . the low immunisation coverage is having disastrous effects." And as millions of displaced Syrians move across and out of the country the risk of polio spreading increases.[5]

Resolve to carry on

Omar Hakeem works in a field hospital in a besieged suburb of Damascus. He, like many Syrian doctors who remain in the country, shows extraordinary resilience in the face of seemingly insurmountable challenges. "We see children dying of hunger. We will continue working to heal these people."

Thanks to the spirit of ordinary Syrian people, limited healthcare provision continues. Alok fled his home to live with his grandparents in inner city Damascus so that he could continue studying. He tells of travelling through the night to the sound of gunfire and seeing families walking on the side of the road with all their belongings towards the city. "I thought I would sit and cry, or be paralysed by the shock and fear. Instead, I said 'bye' to my grandfather and grandmother, took the regular bus, and headed to University Hospital for Dermatological Diseases, where I had clinic duty that day. I arrived a few minutes late to find the clinic had started and the residents had begun seeing patients."

Keir Stone-Brown intercalating fourth year medical student, University of Manchester and science journalism student, City University London, London, UK
Keir.Stone-Brown.1@city.ac.uk

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