'Is life-expectancy likely to become a feature of dinner party conversation?' See End Game, inside back cover

Southend has implemented the *AfC* job evaluaton scheme for its staff, is implementing the knowledge and skills framework and has adopted the pay banding structure. Its terms and conditions in the main mirror *AfC* apart from the relatively minor variations listed in the article. The variations were largely negotiated with the trade unions locally.

Similarly, Ken Hutchinson (Feedback, pages 18-19, 28 September) praises Southend's 'courageous decision'. Mr Hutchinson's claim that *AfC* is unnecessarily bureaucratic and an example of 'centralist control' is frankly ideological rubbish. *AfC* delivers equal pay for work of equal value. It has been delivered in partnership locally and it is sufficiently flexible to meet local conditions. New jobs and roles can be evaluated and ensure that equal value remains. Where labour market conditions require, recruitment and retention premiums or high-cost area supplements can be paid.

A book describing the benefits of *AfC* is due to be published shortly by NHS Employers with the support of NHS unions.

The last thing trusts need is a new round of instability in their pay structures and terms and conditions. *AfC* should be allowed to bed down and to be updated in the light of experience.

There is of course a role for consultants such as Mr Hutchinson, but in pursuing their business they should not try to give the false impression that there is a new, flexible, simple to administer alternative to *AfC*. It has been a great achievement for the NHS and will evolve in partnership.

Hemel transfer

Zena Bullmore, chair, Dacorum Hospital Action Group

While *HSJ* readers are aware that many district general hospitals may lose their acute services and accident and emergency departments (news, page 8, 21 September), I would like to know if Hemel Hempstead Hospital is alone in being transferred to a hospital whose buildings are due for demolition, which is already overcrowded, more difficult to access, has lost its gas supply and has its electric power at a maximum safety level.

Nurses, doctors and midwives are stressed and some are already leaving.

Hemel Hampstead Hospital had a custom-built maternity unit, midwife-led birthing unit and special care baby unit in a block built only about 15 years ago – already moved to Watford Hospital. It also has a surgical block rebuilt 19 years ago, an elderly care block with day hospital 17 years old and and an A&E department rebuilt about five years ago. All this in a growth area.

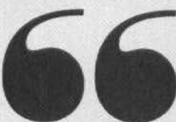
Watford Hospital, where the services are being moved, is due for demolition. It is overcrowded, lifts break down frequently and access is difficult.

It is adjacent to Watford Football Club, which causes serious noise, access and parking problems. We have been promised a new Watford Hospital, but the earliest date for completion is now 2014.

Zena Bullmore (front, third left) leads a march.

SPEAK OUT

BUPA's Dr Natalie-Jane Macdonald explains why there's a key role for commercial companies in commissioning NHS services



In some quarters, private sector involvement in 'buying' healthcare seems to be more worrying than private sector provision. However, effective use of the private sector in commissioning is critical to establishing a cost-efficient, patient-led and responsive NHS.

Effective commissioning could significantly enhance the NHS reform programme. Strategic health authorities and GPs must represent the best interests of the citizen and patient and have a duty to commission the best-quality care they can while ensuring affordability and value for money. However, they face some pretty daunting challenges.

Information to make effective commissioning decisions is patchy to say the least. In addition, PCTs in particular are under pressure to develop the ability to respond to the increasingly complex commercial provider market. There are many drivers of change: financial imbalances, the move from block grants to payment by results and binding contracts, foundation trusts, the growing use of alternative provider medical service contracts, and competition from independent treatment centres, to name a few.

SHAs and GPs must represent the best interests of the citizen and patient... However they face some pretty daunting challenges

Commissioners must rapidly gain capabilities to address these issues within the limited resources available.

There are many aspects of this new environment which are similar to the one faced by private sector commissioners, but there are substantial differences as well. UK insurers commission around £3bn worth of healthcare a year through contracts with private sector providers and NHS trusts (the second largest provider of private healthcare in the UK). Commercial relationships extend to over 30,000 consultants and other health professionals, most of whom also work in the NHS.

These arrangements have to encompass both financial and quality measures and have to encourage innovation and competition. UK insurers have had to develop the systems and processes which are relevant to the NHS.

US-based health maintenance organisations work in a similar context, as do commissioners in many continental and Asian countries where the private sector is more integrated into end-to-end health delivery. Of course there are differences between the NHS, UK insurers, and foreign commissioners such as American HMOs or mainland European health funds. UK insurance is primarily focused on elective work. The US employer-funded system is very different from the UK tax-based system, and complex risk stratification is less effective when those at most need do not necessarily wish or have to engage with the system.

However, in many continental countries like France and Spain (where BUPA also operates) the private sector does end-to-end commissioning of services within a tax funded system so the skills are transferrable. There is also the contentious issue of 'ethical profit', although the argument that private companies are less motivated to deliver quality healthcare than the public sector is seriously flawed.

The private sector has no 'magic bullet' to deliver effective commissioning overnight, nor is it an alternative to the role of NHS commissioners who must ultimately make choices on behalf of patients and citizens. However, capable private companies can supplement the capabilities of NHS commissioners as they seek to exert their influence in an increasingly commercially savvy health system.

***Dr Natalie-Jane Macdonald is director of commissioning services*, BUPA.**