DOCTORS FOR THE NHS
SERVICE NOT PROFIT

NEWSLETTER

SEPTEMBER 2015

Editorial

An article in the Daily Mail in January described the threat to part of our nation's most valued heritage:

"Without major repairs, irreversible damage will be done and it will be lost for ever. Indeed, considering the long-term underinvestment and the intensive use to which it is put, it is remarkable that it continues to function."

This is the Palace of Westminster. That other great British institution, the NHS, is also an iconic part of the UK and only elderly Britons can now remember the worries of having to pay for medical care. The NHS too is now seriously underfunded, with a completely unachievable £22 billion more "efficiency savings" imposed this year.

In England, this decline is from a concerted ideological attack. Although most services are still publicly run there has been a very rapid increase in private sector contracts, particularly in diagnostics, home care and mental health, as well as out-of-hours primary care. CCGs, and also Councils (now responsible for public health and a number of clinical services), are putting more and more clinical care out to tender.

David Eedy describes the "unmitigated disaster'" of Nottingham CCG's outsourcing of dermatology to Circle. Outsourcing to another NHS provider can be just as disruptive, as shown by the inexplicable decision of Chester Council to move the previously excellent sexual health service away from the local hospital to a trust in Macclesfield. Both commissioners seem to be regretting their decisions and are belatedly realising that once a well-run and effective service is dismantled, it cannot just be re-created.

On July 1st, Green MP Caroline Lucas introduced the NHS Bill 2015 which would remove the market and halt this destructive process. We must tell all MPs, as well as the public, how important this is before the second reading in March.

The repairs at Westminster will need hundreds of skilled people. Our local joiner, who did a proper apprenticeship many years ago, says that joinery apprenticeships are now much shorter and also cover bricklaying and plastering. Ben Dean's sterling work on publicising the **Shape of Training Review** shows that a similar process is proposed for postgraduate medical training. A shorter specialty training will be combined with a large "generalist" component, with unavoidable loss of real expertise except for a few specialist centres.

Events are moving very fast. "Devo Manc" and other similar proposals aim to merge health care with grossly underfunded (and means tested) social care. Many hospitals are threatened with closure or downgrading, with dumbed-down or even imaginary "community'" services promised instead. Can it be a coincidence that Lord Prior has announced an inquiry into the future funding of the NHS? All international evidence shows that public funding and provision are the most cost-effective way to provide health care, but this is ignored.

As doctors we are in a position to see what is happening, while most of the public just cannot believe any government would abolish this essential public service. The threats to the NHS are real and urgent. There is much to do.

Persuading colleagues of the need to act will be pivotal to that. We are enclosing one of our publicity fliers with this newsletter, which is itself re-crafted and starting to feature new content as promised.

Please consider showing both to a colleague, and getting them to join. You can order more leaflets from Alan Taman (healthjournos@gmail.com).

Andrea Franks
Editor

DFNHS Meeting With NHS Bill Green MP

Eric Watts and I represented DFNHS at a meeting with Caroline Lucas on 25 June and had over an hour's discussion.

We began by outlining the history and purpose of NHSCA, the recent expansion to DFNHS and our aims and purpose. To supplement this she was given copies of our current literature.

We stressed that we were deliberately not aligned to any political party but at the same time had a policy that we would work with anyone who shared our aims.

Our support for the NHS Bill was emphasised including the previous role of Allyson Pollock as Chair of our organisation.

Whilst discussing the support she would have when introducing the Bill in the House of Commons we explored what opportunities she saw for cooperation with like-minded members of other parties, both inside and outside Parliament. The NHS Action Party was mentioned as having a very similar health policy but she seemed not to have any approach from them (an opportunity?).

She expressed willingness to put down parliamentary questions and would welcome suggestions and background information for this.

There was complete agreement that the purchaser/provider split was the basic cause of most of the current problems but that its eventual removal would need to be by an incremental process not involving another major upheaval. The strong SNP representation might give opportunity for closer scrutiny of how this was achieved in Scotland.

We discussed the difficulty of getting complex issues over to the public and agreed that in the current situation of financial pressures in all sectors leading to cuts etc, repeated emphasis on the £10bn additional administrative cost of the market system was a powerful and easily understood argument.

Although the issue of Devo Manc was raised and we explained some of the concerns, it was not discussed in detail. However it was agreed that we should keep in touch.

Peter Fisher
President, DFNHS

The Doctors' Bill?

Caroline Lucas's NHS Bill 2015-16 is an important landmark, if only because two of its main sponsors – Dr Philippa Whitford, SNP health spokesperson and DFNHS member, and new Labour leader Jeremy Corbyn – are likely to ensure that its passage through the parliamentary process is not the muted, truncated affair the government would favour.

It's important to be under no illusions, though: the Tories will do all they can to cut it short, if necessary relying on filibustering in the committee stage, as they did for Labour's last attempt to address NHS privatisaiton, the Efford Bill, in the last parliament.

That said, this is a welcome opportunity to raise the issue of NHS privatisation, and Jeremy Corbyn in paricular is now in a prominent position to press the government on this issue. The indications are that he will do just that over the coming weeks.

This will mean privatisation is likely to feature, if only briefly, in main news reports occasionally: something the NHS campaigning groups usually have to struggle to achieve and can never rely on.

So the coming weeks are likely to give DFNHS members a rare chance to remind colleagues as yet undecided that the fate of the NHS is gloomy indeed, unless the spirit of the NHS Bill is kept alive.

By joining DFNHS, for instance.

Dermatology Disaster

Circle contract ruins service

The Dermatology Department at Nottingham University Hospital has been a cornerstone in academic and dermatology excellence, probably long before I was born!

Ten years ago it had 11 consultants, each with an international reputation in a sub-specialty, and was world renowned for teaching and training. High-quality publications poured out of this centre. Expertise spanned from paediatric dermatology, contact dermatitis and genital dermatology to a leading centre for epidemiology. Most of this has now been lost in less than 2 years. How did this disaster occur?

The independent investigation[1] into the circumstances that led to the collapse of Nottingham dermatology services has labelled the process an "unmitigated disaster". We are left now picking over the aftermath to see what can be salvaged, if anything can be learned from the needless loss of a world-renowned dermatology centre.

What went wrong?

In the first instance it is important to acknowledge that this service collapse was foreseeable and avoidable. Following the advent of the National Independent Sector Treatment Centre programme under the last Labour government, which sought to increase community based care, outpatient services from Nottingham University Hospital (NUH) were transferred to the new Nottingham Treatment Centre (NTC), run by Circle, in 2008.

At first, a staff supply agreement allowed this service to be largely provided by trust consultants, working shifts in the community centre. However in 2012, Circle won a tender to run the NTC which involved the transfer of the NHS contracts of most of the consultant dermatologists to Circle.

In a letter to the CCG in March 2013, the consultants warned that if this transfer went ahead, most of the consultants would be likely to leave within a year. This was totally foreseeable as a likely outcome. The British Association of Dermatologists estimate that there are 200 vacant posts, so these consultants had ample choice!

Needless to say the transfer of contracts to Circle did go ahead and, true to their word, most of the consultants left.

Speaking to the consultants in the aftermath there was an overwhelming feeling of frustration. It seemed to one of them that their letter, which outlined their concerns regarding patient care, training future dermatologists, teaching medical students and research, was not taken seriously and that the commissioners thought it was a sort of knee-jerk bereavement response to leaving the NHS.

Quite why the commissioners didn't take the warning seriously is unclear. The chronic staff shortages facing dermatology services in the UK mean that not only is it easy for departing staff to find new jobs, but it is difficult to replace them. This alone should have been enough to make commissioners think twice.

Lessons to be learned

Although the independent investigation[1] didn't point the finger at any one group in particular, it is clear that commissioning groups and private providers across the country can learn a great deal about what happened in this instance. It's vital that this opportunity is taken. Commissioning is a complex process and commissioning mistakes made within one specialist service can have serious implications for other services and patients.

That Circle won the bid to run the NTC is no surprise. Private health providers, like Circle, have a necessary expertise in preparing bids that the NHS cannot hope to match. However, bid expertise isn't necessarily an accurate reflection of their ability to run the services. Commissioners need to consider ways that this could be best factored into their decision-making. Circle demonstrated their ability to deliver excellent patient care over 5 years;

however, one might argue that this was largely down to clinical staff seconded from the NHS.

What is a surprise is that the commissioners were deaf to the complaints of their consultants and blind to the circumstances which would allow them to leave and make replacing them difficult. Within the wider commissioning process it's clear that CCGs and trusts need to be ready to listen to the concerns of their clinical staff, and be quicker to read these signs.

Within dermatology itself the Nottingham fiasco hasn't just uncovered issues with the commissioning process but has shone a spotlight on some of the national issues facing the specialty.

For example, not one region in England has sufficient dermatology consultants. The Royal College of Physicians (RCP) recommends one full-time equivalent (FTE) consultant dermatologist per 62,500 population. This scales up to 1.6 consultants for 100,000. Even London, with the highest number of consultants (1.1 per 100,000 population), is still below this figure. 2013 figures for the UK show 684 dermatologists (470.94 FTE) in substantive posts, 93.45 vacancies and 104 locums, while for a population of 61.8 million, the RCP recommended level of consultants would result in 989 FTE dermatologists.

When the majority of the substantive consultants left Nottingham, what did Circle have to do? It turned to employing six non-CCT consultants at a cost of circa £300,000 per annum, massively more than substantive consutants with CCT! As these were non-CCT consultants, this meant that all SpR training had to stop with SpRs being sent to local DGHs. Medical students attending Nottingham University suffered the same fate, being sent to Derby or Leicester for their dermatology attachments.

The Circle treatment centre only dealt with "choose and book" cases, leaving a massive University teaching hospital bereft of acute dermatology care for its large inpatient site. Who looks after the patients in one of the largest specialist University hospitals when the Circle Treatment centre closes its doors at 5 pm and you have acute sick dermatology patients over a large campus?

NUH also provided the specialist paediatric service for the middle of England. This has been all but lost with only one consultant specialising in paediatrics remaining. The professor, who is of international reputation, is only able to give a small clinical input into paediatric dermatology by doing clinics one day a week. This also puts specialist commissioning on paediatric services on the whole Nottingham site on a knife-edge. To be a specialist centre for paediatrics one needs input from all specialties including neurology, ophthalmology, genetics and dermatology. Lose paediatric dermatology and the system fails.

Compared to the RCP recommended numbers, the BAD figures show a shortfall in the region of 250 consultants at present. Inexplicably, one simple measure that could help to increase these numbers in years to come – namely, the allocation of further training posts for dermatology – is not being implemented. In fact, the reverse is occurring, as Health Education England (HEE) reduced specialty-training places in dermatology in 2014-15, despite all protests from the BAD. A recent House of Lords debate disclosed that there is a gross deficiency of around 177 dermatologists in England[2]. Dermatology, already critically understaffed, will face a further dearth of trainees coming up through the ranks to replace retiring staff. The lack of movement to get more trainees into dermatology suggests that this will be a long-term issue.

Conclusion

Because of a total fiasco in commissioning, Nottingham Dermatology has been reduced to a unit where undergraduate and postgraduate training has been totally lost. Wide ranges of its consultants were national consultants in their own right and had a massive research and academic output. These consultants have been dissipated near and far, leaving a service behind which is probably less that one would expect of a DGH! As the independent, report put it: an unmitigated disaster!

It is maddening to have lost such a fantastic service to a catalogue of needless mistakes, but what is really sad is that the brunt of this is borne by the patients, for whom there will be no easy or timely resolution. For these patients the independent investigation, although necessary, will provide very little satisfaction. Despite its scathing tone none of those involved have accepted responsibility.

I cling to the hope that behind the scenes things will change as a result of this mess, and that it may

help to prevent bad commissioning decisions decimating services elsewhere.

I also hope that by highlighting some of the challenges facing dermatology, Nottingham might serve as an impetus to come up with some solutions. My own evidence to the inquiry was that it might be more than a decade before Nottingham dermatology recovers from this disaster. Given the dearth of dermatologists in training, let alone time for young consultants to become international figures, I fear my answer was ambitious. It will probably take more than a generation to re-establish this department of excellence. How sad.

References

1 Clough, C., et al. (2015) Final Report. Independent Review of Nottingham Dermatology Services. Healthwatch Nottingham and Healthwatch Nottinghamshire [online] Available at: http://www.healthwatchnottinghamshire.co.uk/wp-content/uploads/2015/06/Final-Report-from-the-Independent-Review-Nottingham-Dermatology-Service.-4-June-2015.pdf

2 Hansard (2015) Health: skin cancer. Hansard 22 July: Column 1114 [online] Available at: http://www.publications.parliament.uk/pa/ld201516/ldhansrd/text/150722-0001.htm#15072240000327

David J Eedy
President, British Association of Dermatologists

Not Tender: The Blight on Sexual Health Services

"Well, Colm, was it Love me Tender or Heartbreak Hotel?" Such was the enquiry from a friendly colleague when the Council made its decision on awarding the Sexual Health contract.

The Chester STD and HIV service, based at the Countess of Chester Hospital, was well established and had a national reputation for innovation and excellence. Patient feedback was consistently superb. I would say that, wouldn't I, but see patient comments on www.chestersexualhealth.co.uk. Training and education was hugely appreciated by junior doctors, nursing and medical students. In a farcical process that still defies belief, Chester Council took no advice and rode roughshod over all medical opinion from hospital consultants and local GPs, to award the tender to a more expensive bid from another trust, East Cheshire Trust (ECT) 45 miles away.

The new "service", now without HIV services which remain at the Countess of Chester Hospital, has been in place since 1st February and still none of us working in it has the faintest idea why ECT won the contract. Chester Council refuses to release any details of the winning bid, citing financial confidentiality. Should not the public interest trump this? We have seen the service model and cannot believe the proposal to site a hub in Chester, based in a "modular building", moving every 6 months to follow "patient dynamics".

For modular building, Portakabin springs to mind, bringing back memories of the medieval "clap" clinics we used to run in the dark ages. Apparently after several months of trying, Chester Council and ECT gave up trying to design and build a pod in a fitness centre car park [Was this the current centre of "patient dynamics" in this context? I shall visit my local gym and pool with renewed interest. Ed.] and reverted to using a tiny space in a GP complex which had been designed for a small part of our own service. This tiny area is hopeless, generates complaints and many staff have left.

Don't get me wrong – I have nothing but admiration and I am cooperating fully with my new employers, ECT. The management and health care staff I am dealing with there are the usual intelligent, hardworking and compassionate people typical of the NHS. It was not their fault they won the contract.

My problem is with the council, with its secrecy, incompetence and refusal to negotiate or discuss what has happened. Despite exhortations from Public Health England about not dis-integrating STD and HIV services, this does not appear to have even been considered by the panel. The underhand and clever ploy of instant award of contract meant the only challenge possible was an expensive legal one, which the Countess of Chester Hospital was advised was too risky.

I sought personal legal advice and was told to complain formally to

the Local Government Ombudsman (LGO). This office informed me that it would look into it after I had received and rejected two more responses from the council. This of course took several months. Despite the complaints and objections raised by hospital doctors, local GPs, the regional HIV lead, many patients, many Labour and Lib Dem councillors, the LGO refused to examine the complaint. The formal response said that "I had not suffered enough personal injustice to allow them to investigate". Repeatedly, the LGO said that "I was complaining on behalf of an organisation" and this was their excuse for refusing to investigate Chester Council's decision. It did not seem very likely that I could persuade a patient with syphilis formally to complain. Yet we are repeatedly told to "whistle blow on behalf of patients when we see wrong doing" – unless it is a council, of course.

A sham scrutiny committee meeting was held by the council on 6th January. It was an unparalleled display of incompetence and arrogance by the committee. Many doctors and patients attended (http://www.chesterchronicle.co.uk/news/chester-cheshire-news/hiv-patient-asks-council-think-8234914) but no explanations were given for the tender decision. The webcast was on the council website but has been removed.

The local Public Health department was little use in this debacle. Indeed, the director of public health twice wrote to my Chief Executive and trust solicitor warning them "they were vicariously liable for Dr O'Mahony's words and actions" and they were to get him to "cease and desist" from complaining and getting others to protest also. So much for whistleblowing protection. My trust ignored this threat.

In summary these remain the points which need to be answered:

- No declaration of interest forms for a £12.5 million contract (£2.5m pa over 5 years). Why not?
- Maximum amount declared was £2.5 million pa, so why was ECT bid of £2.8 million pa even considered?
- Not one person on the secret panel had ever worked in an STD clinic. Who put that panel together?
- COCH formally complained after initial result so the council simply re-ran it! Second time round the same panel, with the addition of a token, locum GP from Liverpool, who once worked, 9 years ago, in a GUM clinic, was allowed to select the tender again. How likely were they to say "oh sorry, we got it wrong first time"? Should not a whole new panel have been assembled?
- Why were no interviews held? Every other sexual health tender had interviews. How can you judge competence or ability to deliver on paper?
- ECT bid was assembled by a tender management company with no consultant GUM input. CoCH bid was done by 5 NHS consultants and a professional procurement team. We knew exactly what was needed for the specification and had a fantastic track record for innovation and patient care and tendered within the budget limit set. How could the ECT bid have been a better choice?
- Why did Chester Council decide to disallow any challenge second time round by immediate award of contract?
- Why even now months after award is no one able to say what was it about ECT tender that won the day?
- ECT did have an "innovative" plan for a mobile unit as the hub in Chester! They and Chester Council tried for months to plan a pod for the car park in Northgate Arena but this proved a ridiculous plan and had to be scrapped. Who scored that ridiculous "pod" plan so highly that it won the tender?
- At the scrutiny committee, no one could provide any answers to councillors' questions and a vote was refused. Councillors wanted the two bids independently analysed but this was refused.

The amount of money wasted by this ridiculous and damaging process runs to tens if not hundreds of thousands. Which politician dreamed up this piece of legislation designed to destabilise HIV and STD services? Who thought that councils, good, perhaps, at pot-hole mending and bin emptying tenders, would overnight be suddenly competent to tender out complex medical services? This mess is being repeated all over the country and the superb advances made over the last 20 years in tackling STDs and HIV are now in reverse.

Colm O'Mahony
Consultant in Sexual Health, Fountains Clinic ECT; Consultant in HIV, Countess of Chester NHS Trust

The Shape of Training: A Regressive Mess?

Proposed reforms to UK medical education and training have recently caused worrying headlines in the UK, including "Training cuts could harm patients, doctors warn" (BBC News); and led to a coalition of trainee organisations and Royal Colleges to call on the Government to "pause" their plans.

This article aims to summarise the review's key recommendations, the work I undertook in trying to uncover the full context of the review and what this means for the future.

What is the Shape of Training Review?

In March 2013, the organisations responsible for medical education and training in the UK – including the General Medical Council (GMC), Academy of Medical Royal Colleges (AoMRC), and Medical Schools Council (MSC) – launched a review of how doctors were trained, following their qualification from medical school. The review (**The Shape of Training Review**) was commissioned following a number of other reports, which had recommended various changes to different aspects of education and training.

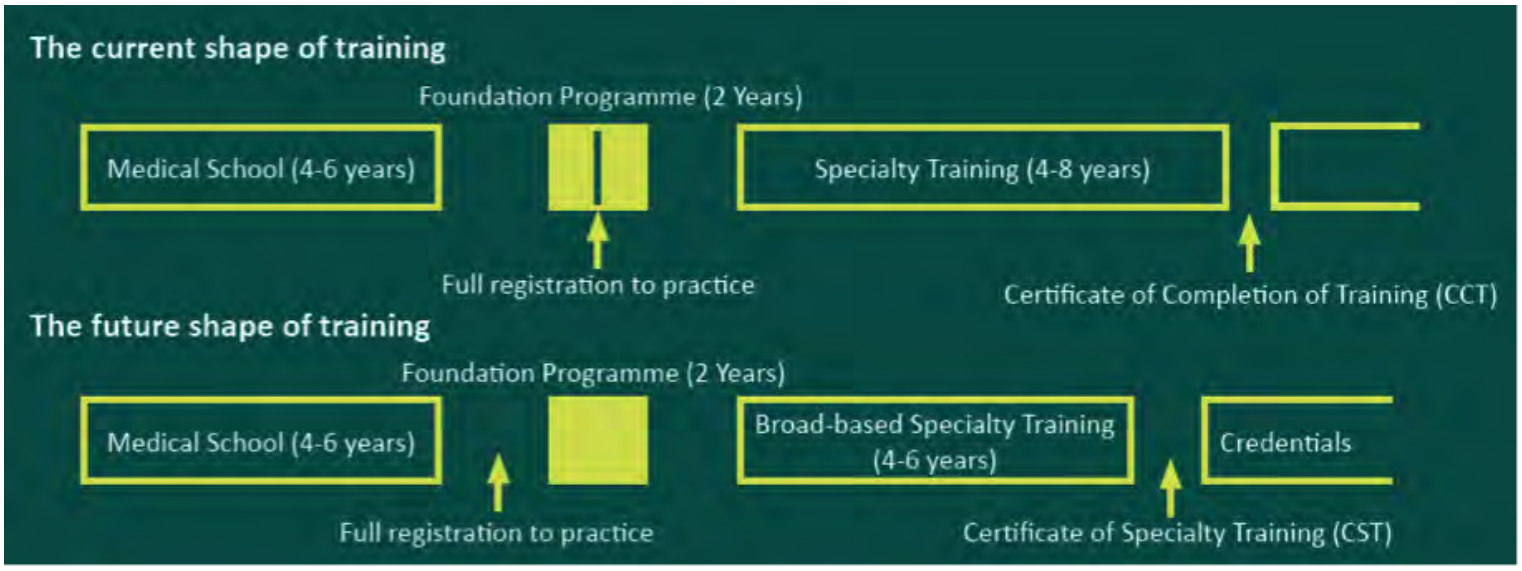
Reportandrecommendations

The review reported at the end of 2013 and recommended major structural change including shortening consultant training by a minimum of 2 years, moving full GMC registration from end of FY1 to medical school graduation and the introduction of post CST (certificate of speciality training) "credentialing" (see Figure 1). The evidence and rationale underlying the recommendations was arguably rather wafer thin.

The smokescreens and controversies

I made a Freedom of Information request to the GMC back in mid-2013 which aimed to investigate whether the review's chair, Professor David Greenaway, had met with government during the review; and if this was the case, what exactly was discussed. The GMC refused my request initially. I then appealed to the Information

Figure 1 The current and future shape of training



Commissioner, who also refused my appeal. I was then forced to appeal this decision to the higher court, the General Regulatory Chamber, where I successfully represented myself against the GMC's QC to force the GMC to release the withheld documents of meetings between the review's chair and senior government figures.

Not only were the withheld meetings not formally minuted, they were not reflected in the evidence summaries of the review or specifically referenced within the review's paper trail, demonstrating a worrying lack of transparency.[1, 2] The meetings which potentially influenced the review included No10's chief health adviser, senior Department of Health (DH) officials and government ministers.

In one meeting senior DH officials revealed that ministers were "setting strategic direction and feeling happy", notably the review had not yet completed its oral evidence sessions at this time point. The DH later described their meetings with the review chair as "routine engagement",[3] calling into question the true "independence" and transparency of other recent reviews. It was interesting that the GMC spent over £4,000 on QC fees alone in resisting this FOIA request.

Not only did the review fail to be fully transparent, but within some of secret meetings it is clear that unpublished DH work may have influenced proceedings; of note this unpublished work was not referenced within the review's paper trail and was not available to the general public.

For example a meeting involving the review's chair, Paul Bate (No10's chief health adviser), and the GMC referred to "unpublished work within DH looking at possible re-configuration of A&E and the level of staff (consultant or non-consultant) needed to support such a model". This observation adds weight to the argument that the review is more motivated by the needs of service providers than that of patients.

Shorter and cheaper hospital consultant training – patients at risk?

The majority of the review's consultation respondents felt training of hospital consultants should not be shortened but this is precisely what the review recommended doing by at least 2 years. While the review did precious little to address current problems in training such as training quality, training post regulation and an over-reliance on poorly validated tick-box competency based assessments.[4]

This reduction in the standard to which consultants are trained is not only a significant threat to patient safety according to the RCP and BMA, but it also threatens to water down training quality further by reducing the experience levels of our consultant trainers.

Quite how "generalist" consultants can be trained in less time has yet to be adequately explained by those implementing the review's recommendations. It is ironic that Terence Stephenson noted in a meeting with Professor Greenaway "that doctors from overseas with shorter training often had a much narrower range of skills. If we want shorter, narrower training we will need to think about how to support an NHS which wants broad skills". It appears that the current GMC chair felt that shorter training leads to narrower skills; this seems totally incompatible with the review's claims of being able to train competent generalist consultants in less time.

The reality of the review appears to be more compatible with rebranding "generalist" registrars as "consultants" in a way in which is likely to deceive the tax paying general public.

Marketising training?

Released meeting notes state that Derek Gallen "felt that new private medical schools might help by creating a better market of trainees. If there is to be a cap on the number of F1 places, a medical school will have a competitive advantage if it shows itself to be more successful in getting its trainees into F1 posts" within a meeting involving Professor Greenaway and the GMC.

This evidence points to a potential link between the review's recommendation to move the point of full GMC registration and creating a market over-supply of medical graduates.

Not only this but this new breed of "consultants'"will only be able to become proper specialists using a new process of formal accreditation called "credentialing". This change would see employers handed the power to decide whether you could effectively complete

your consultant training or not, inevitably many would end up stuck in a dead-end "sub consultant" type position being used as rota fodder.

Credentialing would also likely pass the costs of training onto the trainee "consultants" and the benefits of this potentially burdensome bureaucracy are totally unproven. This creates another potential bottleneck in the system and room for a potential over-supply of CST holders.

In the context of recruitment crises in primary care and A&E, alongside worsening recruitment problems in areas such as hospital medicine, the potential creation of an over-supply of graduates and CST holders risks further hitting this expanding recruitment disaster. Certainly an economist may argue that the over-supply will lead to cheaper labour costs, but at what price?

If it means reducing the quality of medical school applicants and graduates, as well as worsening the widespread medical recruitment crises, then this may be at a huge cost in terms of both being unable to recruit and also in terms of reducing the quality to which doctors are trained.

The future

Numerous professional bodies including the RCP, RCSEd and the BMA continue to have significant concerns about the direction of travel of ShoT, as well as over 6,600 individuals who have signed my petition to halt the review's implementation process.[5]

The RCSEng's limp stance coincides with the fact that their president, Clare Marx, has been intimately involved in the review from an early stage. The non-specific statements from the review's Steering Group are far from convincing in my opinion and it is notable that none of the specific safety concerns have yet been adequately addressed.[6] It is far from impressive that so few specifics have yet been confirmed by those implementing the review, while the lack of grass roots involvement appears to be a persistent problem.

"Numerous professional bodies ... have significant concerns about the direction of travel of ShoT"

The Association of Surgeons in Training's (ASiT) recent statement neatly summarises the Steering Group's continued failure to mention specific details and total lack of comment on training time.[7]

It will not be enough to justify the shortening of consultant training by falling back on poorly validated "outcomes" like workplace assessments and ticking boxes off against a curriculum.

Patient safety must be given more priority and any changes to training time must include the robust measurement of patient outcomes using only well-validated and sensitive measures.

Finally I would urge that any of you have concerns after reading this, then get involved, sign my petition,[5] distribute it on the social media and write to your MP, every little really does help.

References

1 GRC (2015) http://wwwinformationtribunalgovuk/DBFiles/Decision/i1428/Dean,%20Benjamin%20EA20140063%20(031214)pdf

2 Dean, BJF (2015) 'GMC's supposedly independent training review included secret meetings with politicians'. BMJ (Clinical research ed). 2015;350.

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4 Pereira EA, Dean BJ. (2009) 'British surgeons' experiences of mandatory online workplace-based assessment.' Journal of the Royal Society of Medicine. 2009 Jul;102(7):287-93. PubMed PMID: 19605860. Pubmed Central PMCID: 2711198. Epub 2009/07/17. eng.

5 Dean B. (2015) Petition https://you38degreesorguk/petitions/stop-the-shape-of-training

6 Group SoTS (2015) Statement. http://wwwshapeoftrainingcouk/static/documents/content/Shape_of_Training__UK_Steering_Group_statement__Approved_version_16_2_15pdf_59780421pdf

7 ASiT (2015) Response to Steering Group. http://wwwasitorg/assets/documents/ASiT_Response_to_STSG_Report_17215pdf

Benjamin Dean

Shape of Training: GPs

A generalist works with undifferentiated problems, with symptoms and not with diagnoses, with problems such as "tired all time" or "pains all over". They help sift through the two million or so problems that the one million or so patients present each day to the health service. Without generalists at the front end of health care, the system would grind to a halt.

There is no health service, private or publically funded, that can deal with the growing demand for health care. The evidence, from this country and from overseas, including the USA, shows that the more generalists per head of population, the better the health outcomes, the better the public health indices and the lower the health costs. So, given this, we have the paradoxical situation, of an interminable rise, not just in specialists, but also in sub-specialization, the physician that only deals with Type 1 diabetes, or the orthopedic surgeon that only deals with shoulder problems, etc.

The last of the generalists are GPs, emergency care doctors and liaison psychiatrists. Even elderly care doctors – who would not so long ago have dealt with the totality of the patient (albeit only if they were over 65 years of age) – are now increasingly dividing themselves up into care of the frail elderly, falls expert, care of patients at end of life, and so on.

For GPs we have the triple whammy of decreasing investment, reduction in numbers entering the profession and the shortest training – not just of all doctors in the UK, but also of all comparable GPs across the world. In only 3 years post-foundation training, we are expected to be experts at everything – managing patients that 10 years ago would have been seen entirely in hospital out-patients and dealing with increasing complexity and having to care for patients with multiple conditions. Yet, we have only 3 years' training.

On the whole GPs spend time training in broad, over-arching areas. So for example, the medical part of their rotation might be in the care of the elderly, or in neurology – different subspecialties but still common themes. The posts have to be approved as being suitable for training and providing sufficient variety to cover the competencies needed. In the current 3 years, with one year in GP, this leaves 2 years. These 2 years can be anywhere: in hospital posts, community posts, or a mix of both. These 3 years are not long enough to give the doctor confidence though they might be competent.

GP trainees are leaving training with the competence to work, but not the confidence. There is also a lack of understanding that hospital colleagues have of general practice and that the skill of the GP is to reduce uncertainty and minimize risk, something that outwardly looks easy but actually takes tremendous skill. Three patients, all with sore throats, will have three different aetiologies and three different managements. One might be a simple viral illness, one due to anxiety, and one due to cancer. The GP has to determine which is which, all in 10 minutes. Referring all patients for tests would bankrupt the health service and lead to more problems for patients.

Increasingly care is being moved out of hospital into the community – sadly without the simultaneous shift of resource in terms of money or staff. Hospital specialists are reluctant to move outside the front door of their hospital. This is largely through their unfamiliarity, as few doctors in training set foot in general practice and their only contact with the GP is via the referral letter or when patients present in accident and emergency.

Shape of Training set out a vision for medical training that would have had most doctors having some experience in general practice, or at the very least in community settings (for example, community paediatrics, psychiatry, care of the elderly).

The proposed foundation training will be 2 years, followed by 4 years instead of the current 3. The proposal is then for trainees to spend 2 years in general practice, and to cover 18 specialties in the remaining 2 years, dependent on the available rotation. GP trainees would spend at least 6 months in psychiatry and 6 months in paediatrics. With around 300 specialties GP trainees won't be able to cover all of them, but the extended training should at least ensure trainees emerge with a more rounded experience and knowledge.

The patients of the future, as we live longer, with more complex and multiple conditions, will no longer have single issue or single system problems. All doctors in the future must be skilled at caring for

patients with undefined or complex conditions.

The rationale

What the new training proposed for GPs reflects is:

- Patients are likely to need more general specialty care and expertise as healthcare shifts into the community. Most doctors will have to be skilled in caring for patients with undefined or complex conditions in local and community settings and to provide both acute and non-acute care. Training should focus on giving all doctors the capabilities to care for acutely ill patients, patients with short-term issues, patients with long-term conditions as well as advise on prevention of illness.
- Care should be delivered by multi-professional teams, who facilitate access to the right interventions by the right health or social care professional for each patient as an individual. Within teams, doctors should provide leadership and support throughout a patient's journey to patients/carers, colleagues and teams as a whole. Doctors as part of their training should follow patients along a care pathway in community and hospital settings.
- Doctors, alongside the teams in which they work, should be empowered to make decisions in collaboration with their patients and other professionals about how to provide care to individuals and the community. Doctors should be trained and supported in understanding their responsibilities to deliver safe and high-quality care. Their training should reinforce their professional responsibilities to patients and the public, including the importance of medical conditions and treatments being set in the broader context of patients' lives and environments.

Learning and development

Learning and development never ends and value should be given to training and development throughout doctors' careers. Doctors should be encouraged to take on management, leadership and education roles as they progress in their careers. Doctors who are not working at the level of a trained doctor should be recognised as still in training, including doctors who are focusing on academic, research or management areas.

Doctors should have a longer period of time before they decide their specialty, although some doctors may want to start differentiating earlier in their training by building up their training within themes.

Doctors should have flexibility to move between roles and specialties at any point in their career. There should be a mechanism for recognising different points in training and development where doctors have built up skills, capabilities and experiences that show they are competent to provide care at that level.

Doctors should be able to transfer their competencies across specialties and roles as they move through their training. This will be helped by more emphasis during training on developing and honing general and broad-based knowledge and skills.

Doctors during their training should have support and supervision that is right for their individual learning needs and level of training for their specialty. Far more direct supervision and support is needed when doctors are building up their knowledge, skills and competence. But the intensity of supervision may shift to more indirect support and mentoring as doctors begin to work more independently.

Doctors have better learning outcomes when there is continuity in their training and they work with specific trainers and within consistent teams. This means that rotations during training may need to be longer to build up effective relationships in teams and with supervisors.

Places that train doctors must foster learning environments and have the capacity and resources to support training. Doctors need to have enough experiences or access to experiences to meet their training requirements.

Doctors should be given time to learn, train and reflect on their training even while providing care to patients and working within the health service.

Although all doctors should have a grounding and understanding in academic medicine and research, there is no expectation that all doctors should undertake academic or research work.

Professor Clare Gerada
Clare works as a GP in London and is a former President of the RCGP

"Cut the bureaucrats" ... THEN Count the Cost?

Cancer Commissioning and the Price of Market Ideals

More than 1 in 3 of us will get cancer and most now survive more than 10 years from diagnosis. The quality of that life is variable and this has become an important issue in its own right. Yet is now largely ignored, thanks to the malign influence of the Health and Social Care Act (HSCA). Leaving many lives blighted and guaranteeing greater poverty.

In 2010 the then Cancer Czar Mike Richards, with Ciaran Devane (CEO of Macmillan, the cancer charity), jointly announced The Cancer Survivorship Initiative. This detailed the health problems that affect cancer patients once their hospital treatment is over. They stated:

> **"For a proportion of the 1.6 million people living with and beyond cancer, we are neither identifying their needs, nor meeting them. We now have a range of evidence which suggests that cancer follow-up arrangements do not address the full range of physical, psychological, social, spiritual, financial and information needs that cancer survivors may have following their treatment."**[1]

This study also documented the poorer health and well being of patients. The Survivorship Initiative sought to address these with a series of projects involving holistic needs assessments, appropriate rehabilitation or supportive treatments. The progress made was reported in the DoH document **Living with and Beyond Cancer** published in 2013[2].

This was the culmination of 5 years work by the National Cancer Action Team and associated working groups which had a staff of 25 people. But instead of that group continuing, it was dissolved, along with the PCTs, to be replaced by NHS England and CCGs.

At a stroke we lost the infrastructure to support the improvement in cancer services: the National Cancer Action Team, the Cancer Networks, not to mention the working relationships and partnerships which are fundamental to delivering joined-up services. All were swept away without any replacement beyond a legacy website.

What has happened since? CCGs have been given the task of commissioning services but in general they have not identified a need to commission cancer rehabilitation. In spite of the progress made in treatment, meaning more patients are living longer with cancer and have more enduring needs, CCGs have not been helped by NHS England in how to plan or commission these services.

David Cameron recently spoke proudly of the fact that he got rid of bureaucrats from the NHS.[3]

But what he didn't report was that some of these "bureaucrats'"were doing useful work developing much needed services. Now no one is planning them and patients are suffering. Where there were projects and plans there is now confusion and inaction. There is no structure.

The working networks which organised and delivered care were dissolved to be replaced by "Strategic Clinical Networks" – which discuss strategy but do not deliver, and were described by one Survivorship Committee member as "a man and a dog instead of a full team with no accountability and no apparatus for peer review".[4]

The DoH had a team of 25, replaced after the HSCA in 2012 by only a legacy website.

Did they really imagine that long-term issues for cancer patients would disappear?

NHS England now has 2 people working part time on the problem. A tardy acknowledgement that they still have work to do, but it raises the question – what were they thinking? NHS England has effectively abandoned the Initiative.

Yet, as so often is the case when ill-thought out political ideology is applied crudely to medicine, narrow-minded obsession over deficit reduction is in fact costing more both in the long run and overall immediately. For example, the financial savings in "getting rid of the bureaucrats" needs to be balanced against the savings that could have been made (both in monetary terms and quality of life benefits). **Living With and Beyond Cancer** makes this plain:

> **"In total, it was estimated that cancer cost the English economy over £18 billion in 2008, with nearly £5.5 billion of this sum related to lost productivity from cancer survivors. In addition, a significant proportion of the overall cost of cancer services to the NHS results from support for cancer survivors."[5]**

One of the workstreams blindly axed was getting survivors back to work, as often they're fit enough but have lost confidence. If they had spread the word from the successful pilot sites the £5.5bn could have been reduced considerably.

If ever there was a clear case of "throwing money away" this is it: by not maintaining proper investment, the economy is worse off. Surely a glowing example of prudence sacrificed for dogma. Were money the only thing lost that would be bad enough; but to lose money and leave people's lives blighted by fear, despondency and ignorance is a failure of governance itself.

Since the HSCA was passed members of the Cabinet have said it was their worst mistake.[6] This example shows not only that the new structures cannot deliver health care as well as the NHS prior to the reorganization; but that they are costing more money and failing people while doing so.

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Eric Watts
Chair, Doctors for the NHS, and Medical Adviser to the National Conference of Cancer Self Help and support groups

Cancer Not For Profit Gaining Ground

The provision of cancer care in Staffordshire continues to be a major focus for NHS privatisation.

Open Democracy leaked the highly controversial £700 million tender for Cancer Care in Staffordshire in March, which include handing all responsibility for commissioning cancer services for 800,000 patients to a "prime provider" – which can be a private company – who will then sub-contract services to companies of their choice.

A growing campaign against the proposal, "Cancer not for profit", is successfully engaging widely with the public on Facebook: https://www.facebook.com/cancernotforprofit

Vanguards:
A Sinister Step

Vanguards are the name given to embryo "new models of care" (NCMS), as described in Simon Stevens" NHS Five Year Forward View (FYFV) of October 2014.[1]

The NCMS listed in the FYFV are Multispecialty Community Providers (MCPs), Primary and Acute Care Systems (PACS), viable smaller hospitals, acute and emergency care networks, specialised care, enhanced care in care homes, and groups of midwives contracting with the NHS to assist at home births.

A call was made by NHS England (NHSE) for applications of interest in January 2015, to "local leaders" to set up MCPs, PACS and Enhanced care in care homes.

On 10 March 2015, 29 of these sites were chosen with 9, 14 and 6 of each respectively.[2]

Another is Greater Manchester, which following the Devo Manc deal in February 2015 was hailed as the top Vanguard, "trailblazing" the way for the objectives of the FYFV. The Vanguard in "specialised care" is the 10 year Staffordshire £700m contract for cancer care.

On 20 May, expressions of interest were requested for "new models of acute care collaboration" and then on 3 June, for NCMS focusing on Urgent and Emergency care (UEC).

The first eight of the latter were announced in July[3], to be followed by 23 UEC networks across England.

Professor Keith Willett, NHSE's director of acute episodes of care, said: "The solution does not lie in simply providing more and more emergency departments. It's clear that that we need to deliver a step change in the way that health services in this country are used and delivered." It was "equally important" that the new networks "support and improve all our local and emergency departments, urgent care centres, GPs, NHS 111 and community, social care and ambulance services".

London two-tier A&E

The London Urgent and Emergency Care Network specifications[4] (June 2015) confirm plans for two-tier Accident and Emergency Departments: Emergency Centres and Specialist Emergency Centres. Previous NHSE reports demanded a reduction of 40-70 in District General Hospitals (DGHs) containing a full A&E.

The DRAFT Urgent and Emergency Care Facilities Specifications[5] (August 2015), describe the following facilities: urgent care centres (UCCs), "Emergency Centres" and "Specialist Emergency Centres". The draft states that only the latter will provide the full back-up of the necessary consultant-led specialties to provide safe emergency care. The first two rely on being able to transport a seriously sick patient, by ambulance, to a hospital with a Specialist Emergency Centre.

Cut and cut again

Greater Manchester CCGs announced in June the downgrading of six DGHs to "local general hospitals". The Northumberland PACS is founded on the removal of A&Es from Hexham, Wansbeck and North Tyneside hospitals. North-west London Vanguard is predicated on the removal of A&Es at Hammersmith, Central Middlesex, Ealing and Charing Cross hospitals.

However, the most detail has now been published for MCPs, PACSs and enhanced care in

care homes in two new NHSE documents: **The Forward View into Action, New Care Models; update and initial support**[6] in July 2015, and **Forward View into Action. Registering interest to join the new models of care programme**[7] in December 2014.

250,000 a piece

These state that MCPs can develop into very large out-of-hospital providers (30-50,000 registered patients). The FYFV says that MCPs could take over what remains of a DGH, so it could have more than 200,000 patients. MCPs could provide primary care, aspects of secondary and mental care, community, preventive, and out-of-hours care, and social care. PACSs would be larger (with 200,000 to 250,000 registered patients), starting with an acute hospital trust vertically integrating with community care, local GPs, mental health and social care. To carry the clinical risk for acute hospital care, a larger population base is required.

The ability of these entities to provide (or commission to provide, as they do not have to directly provide but could subcontract out to other providers, through a variety of contracting mechanisms) depends upon cooperation of commissioner leaders (CCGs, Local Authorities and local arms of NHSE), and the fusing of their various health and social care budgets into one pot, which can then be directed into the MCPs and PACSs.

It is stated that MCPs and PACSs "have their own organizational capability, and are invested with the power and ability to reshape care and delivery". Once the care is costed, these are to be given a capitated budget, as payment for a contract for the care of a given registered population, for a time period.

US model the end-game

ACOs (accountable care organizations) were developed in the USA as a key feature of President Obama's 2010 Patient Protection and Affordable Care Act. It proposed that ACOs would be used to replace the traditional fee-for-service arrangements for Medicare. ACOs would participate in a "shared savings programme" if they improved care and reduced the cost of providing healthcare to a defined population of patients. The payer and ACO would share any savings between them. Private US health insurance companies, such as Aetna and Cigna, also developed ACOs.

On close reading of the literature on ACOs, it becomes apparent that the £22bn efficiency savings anticipated by the FYFV, is to come from (a) a huge reduction in hospital admissions, (b) rationalising of NHS infrastructure and estate, and (c) radical changes to the workforce and new ways of working. The key purpose of ACOs is "lowering the per capita cost of care" [8]. The admired goal is Kaiser Permanente, "a single integrated system" US health maintenance organization (HMO). HMOs became notorious for making money by imposing managed care pathways, denying necessary hospital care, and charging co-payments.

The report by the Primary Care Workforce Commission **The Future of Primary Care, Creating Teams For Tomorrow**[9] gives us a glimpse of the workforce changes planned for MCPs. "Multi – Disciplinary Groups" – which can include nurses, pharmacists, social workers, paramedics and managers of care homes – are encouraged to take clinical decisions, formerly the preserve of medically qualified practitioners. Seven day working is demanded.

This article can only skim the surface of the massive changes to administration and healthcare delivery planned in the FYFV, the purpose of which is to impose an American style, insurance based, health system in the UK. The Vanguards are another dangerous step on this journey.

All those who cherish our publicly funded and provided NHS must vigorously oppose these changes, and defend our GP surgeries, our DGHs, and our national publicly funded, trained and provided workforce on national terms and conditions.

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And while you weren't looking – Government launches fees agenda

The newly-appointed Tory Minister for NHS Productivity, Lord Prior, has set up a fresh inquiry into the possibility of funding the NHS through user fees for service.

The proposal appeared to emerge informally in the course of a low-profile debate in the House of Lords, but it has all the trappings of a stitch-up – since only like-minded peers seem likely to be invited to take part in discussing this "zombie" idea.

Prior's call has been swiftly followed by a report from CIPFA – the Chartered Institute for Public Finance and Accountancy – which dismisses the chances of the NHS making the required £22 billion of savings over the next 5 years. It concludes from this that the government must either come up with more money for the NHS, or reduce services, or ... "charge users more", arguing that: "To choose none of those is not a realistic option."

We can expect an orchestrated campaign of such arguments to grow in the next year or so. This raises the possibility of the new government publicly flouting David Cameron's previous explicit insistence that patients would not face charges for treatment or be required to take out health insurance.

A diehard right-wing fringe of the Tory party has always argued for charges to access NHS services. They never accepted the premise of Bevan's NHS, which was to eliminate the cost barriers to health care for everybody. The principle was that the NHS was funded on the basis of general taxation,not by charging the sick.

The inescapable problem facing anyone wanting to urn the clock back in this way to the 1930s is that most health care is needed by those who are least in a position to pay any significant price for it. And health care is not the sort of service which people who don't really need it would access simply because it's free.

We have a right-wing Tory government determined to use its 5-year term to slash public spending and open up as much as they can of the NHS to the private sector. But the private sector will take care to ensure that any services they take over are publicly funded, to guarantee numbers of patients and fat profits.

– This abridged article appears in the new quarterly joint newsletter produced by London Health Emergency and Keep Our NHS Public. Go to www.keepournhspublic.com or tel 07497 434630 to order copies.

"The NHS is Safe In our Hands": Is That So?

No! I'm not intending to challenge our politicians over this oft-repeated fantasy slogan which they wheel out to a naively insatiable public but instead wish to ask the same question of ourselves and those who represent us.

My long-suffering wife is already alert to the prospect of something dangerous afoot when, with dawn breaking, I announce that I must engage immediately with my computer downstairs to get something off my chest. "You're losing your marbles again" she chides as she turns over, and having cursorily checked that my night attire is intact, and that no marbles are visible, I realise that she is merely reminding me that I am cognitively impaired.

She is probably right but I still have sufficient memory and awareness to recall and to remind those of you who have read or not read earlier Newsletters that I have asked related, some might say provocative, questions before under various guises such as in "Time to put our own houses in order?""(Editorial September 2011) and in I'll huff and I'll puff" (Editorial June 2012) and that I am still awaiting answers or at least reactions.

Perhaps the proposal to introduce a correspondence column will provide the opportunity for debate and the challenging of views?* I hope so.

But I must return immediately to my main concern contained in my title, by fine-tuning the question.

Where is the evidence that our medical establishment is taking a central, active and constructive role in debating and working with government over major issues affecting the future of our NHS beyond challenging funding proposals?

> **"Jeremy Hunt is shaping up as ... the most far-sighted Health Minister since Bevan"**

I use the short-hand global term "medical establishment" out of a sense of frustration sensing that what I am searching for probably does not exist, namely a single, clearly identifiable, medical leadership body which has a vision of the NHS of the future and is prepared to share it with government, and with the electorate responsible for appointing it.

It is a concern recently articulated by Mark Newbold in a BMJ guest editorial (1 August 2015) in the context of the skirmish over 7-day working. I share his concerns over the way the profession's "representatives", the BMA, have been manoeuvred into a corner by Health Secretary Jeremy Hunt, who while outlining his grand vision for the NHS in a seminal speech at the King's Fund on 16 July made direct challenges to the BMA as "not remotely in touch with what its members actually believe" and who stated that he was prepared to impose a new contract if there has been no agreement after a 6-week negotiating period.

Even more concerning than the familiar passive-defensive victim role assumed by our representative body and the direct challenge to its authority is the central stance assumed by Jeremy Hunt in his vision of the cultural change needed with his emphasis on "a transition to patient power" which he argues will dominate healthcare for the next 25 years and which will not only "need patients to be willing and able to harness technology" but by implication require our profession to be prepared to make fundamental changes.

Although he makes direct reference to 7-day working in his speech as one vital change needed, which may or may not be negotiated to the satisfaction of government or profession, there are surely other key areas of potential and indeed current conflict requiring urgent mature debate with government.

For example, the future pattern and delivery of NHS provision of primary and secondary care and the implications for under-graduate and post-graduate education reform, even dare it be suggested with the Greenaway Report.[1]

Again, the worrying questions cannot be avoided. Where is the medical leadership which is prepared to look beyond the narrow self-centred focus of challenge to perceived threats to time-honoured contract freedoms for GPs and specialists, freedoms which were established long ago in negotiations with Bevan? Do we have to spend so much time and confrontational energy propping up a primary care service where GPs remain central to its delivery in the face of overwhelming evidence that a new generation of medical graduates is voting with its feet to avoid the speciality?

And why are our medical educational establishments and our Royal Colleges not working together with urgency to find ways of making entry into certain service-deprived specialities such as emergency medicine and psychiatry more attractive?

It is an all too familiar tune of isolated groups of medical establishment bodies leisurely pursuing their own agendas with the NHS service delivery implications usually of secondary concern.

I happen to believe that Jeremy Hunt is shaping up as the most innovative, far-sighted and courageous Health Minister since Bevan*, despite having to operate within a government displaying much opacity over the future of our NHS, and yet even he is in need of urgent guidance from our profession, with representatives speaking with one authoritative NHS-committed voice.

Does DFNHS fit the bill as this much needed leadership body or is it destined to remain a pressure group, albeit a vital one, in reminding cynics of the fundamental principles and strengths of our NHS? Well of course we all believe it does, or should, were it to have more members and more recognition of its status from within the profession, and therein lies a challenge.

Meantime, I fear that the future of our NHS is not safe in the profession's hands, for the reasons I have outlined, and that we need to recognise this whenever we claim otherwise.

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Devil's Advocate? Let us know

The article on this page is deliberately provocative – the author makes that plain.

As part of the redesigned newsletter, future issues will feature correspondence from readers as well as more analysis of current NHS news. That requires comment from readers to work!

So please, send your comments to Alan. We will then run the best letters in the next issue. We would also appreciate your comments on the changes. We think it is a great improvement, but of course it is not the only possible one.

You should be receiving this copy just before our AGM, in York. The next issue will cover the AGM in more detail, but check the website in the meantime (www.doctorsforthenhs.org).

Extra? Extra? Newspapers and Weekend Working

Assessing accurately the impacts on healthcare of different levels of hospital staffing is a complex and expensive process. In this, it is like many other aspects of "careful research into the operation of health services" – what is normally called health services research. The government"s spasmodic advocacy of a "24/7 NHS" is simplistic in research terms, and in relation to health policy and management.

On 16 July 2015, five national newspapers reported on their front pages that Jeremy Hunt, the Health Secretary, had "declared war" on doctors about NHS weekend work.

These press reports were written by general political staff rather than health correspondents and therefore, as might be predicted, the reports in the different papers were remarkably similar and heavily dependent on the department of health's press release – reflecting the growing trend towards "churnalism" in the UK press.[1] The false impression was given that currently no consultants work at weekends.

The Times headline was "Get real and work at weekends, doctors told". The **Daily Telegraph** headline was "Hunt goes to war with doctors" while the **Daily Mail** shouted "Top doctors told: work weekends".

The **Guardian** report was also on the front page, headlined "Hospital consultants face ultimatum" while the **Financial Times** noted on its front page that page 2 reported "Hunt ready to push through 7-day terms for consultants".

The **Daily Express** report was on page 7, "Consultants must work weekends to cut NHS death toll". The **Independent** also reported the speech on an inside page – "New doctors will be forced to work weekends in seven-day NHS plan".

The **Morning Star** did not report the health secretary"s speech on 16 July. It took an extra day and got beyond a regurgitation of the department"s press release. Paddy McGuffin's informative report appeared under the headline "Hunt angers doctors over threats to force seven-day contracts".

Under the subheading "7-day care" the department's press release reported the Health Secretary as saying:

> **"Around 6,000 people lose their lives every year because we do not have a proper 7-day service in hospitals. You are 15% more likely to die if you are admitted on a Sunday compared to being**

admitted on a Wednesday. No one could possibly say that this was a system built around the needs of patients – and yet when I pointed this out to the BMA they told me 'get real'. I simply say to the doctors' union that I can give them 6,000 reasons why they, not I, need to 'get real'. They are not remotely in touch with what their members actually believe."

It is relevant to ask why the Health Secretary was focusing on doctors and their union, the BMA. Additional weekend working has implications for all healthcare staff and for additional resources.

The Times was the only paper to mention that the source of the 6,000 deaths figure was research reported in the **Journal of the Royal Society of Medicine**.[2] However, **The Times** report did not discuss the reliability – or otherwise – of the controversial 6,000 figure.

The JRSM study objective was "to assess whether weekend admissions to hospital and/or already being an inpatient on weekend days were associated with any additional mortality risk".

The study analysed all the admissions to the English NHS during the financial year 2009-10. It followed up all 15,061,472 patients for 30 days and concluded (emphasis added):

"We have found clear evidence of an excess of mortality associated with admission to hospital on weekend days in the [NHS] in England and in not-for-profit hospitals in the USA. Although being admitted at the weekend is associated with increased risk of subsequent death, we also found corresponding evidence of a reduced risk of death occurring among patients already in hospital on weekend days versus week days.

"It may be that reorganized services providing 7-day access to all aspects of care could improve outcomes for higher risk patients currently admitted at the weekend. However, the economics for such a change need further evaluation to ensure that such reorganisation represents an efficient use of scarce resources."

Amen to that.

The main impression that I have from these battles is that public health professionals need to contribute to the public discussions. It is no good being superior in private judgements while the public discourse is left to be muddled and misleading.

Ways have to be developed for getting informed public health perspectives into the media.

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Peter Draper

Not on Track?

The fate of our nationalised railway network has much in common with what is currently happening to the NHS.

After nationalisation in 1948 the railway network was as much a social enterprise as a commercial money-spinner but an increasing gap appeared between the income from rail users and the cost of delivering the service. That gap could have been filled by increasing taxation, but such a measure was anathema to the Tory Establishment. A simpler solution was to close one third of the network. This process was partially hidden by the smokescreen of a massive Treasury investment in the road network. However, all this could not have gone ahead without changes in the law: the Transport Act 1962.

"Beeching" the NHS, using a similar change in the law, was all that was needed by the Establishment and its Tory supporters. There were no concerted cries of "foul" from the medical profession. Our social consciences may be working in the consulting room, but collectively the profession are in many ways on an equal footing to the current Tory majority in parliament.

The Politics of Despair: Grab Them by the Throat

There's a scene in one of the Terminator movies, where the android Arnie – part killer-machine, part wooden-style actor – picks up the despairing leader of the resistance by the throat as he sits huddled in a corner because he thinks there is no way out and the heavily armed police (this is the USA) are about to come in, guns blazing.

"What the hell are you doing?", blurts out the leader as Arnie puts him back down again.

"Anger is more useful to me than despair", replies the actor/cyborg.

Suffice to say that they get away, only the bad guys (and robots) are killed and the leader goes on to survive another two sequels (more or less) intact.

The point being, despair is rarely useful in any fight. Which is where much of the anti-NHS-privatisation movement (and I think I can call it that; we're big enough) found itself on waking up to a Tory majority. Five more years of THIS? But we've been doing it for so long. And what on earth are the electorate doing? Don't they see they've just handed back the NHS to the worst possible political group they could? Huddle. Floor. Armed cops approaching.

Part disbelief, part confusion, part exhaustion. But the really nasty part of despairing politics is that it can trigger not just immobilisation, but also fractious in-fighting, self-doubt and mutual recrimination. We don't need armed cops, we're perfectly capable of shooting ourselves in both feet while blaming the other leg. All the energy that could have gone into fighting the real battle is turned inwards.

"What reinforcement we may gain from hope; If not, what resolution from despair"

– John Milton, Paradise Lost

I've seen this a lot lately. And if that were the only direction there wouldn't be much more of a story to tell: the in-fighting would become terminal and groups that have achieved so much, both locally and nationally, would simply cease.

But it's not. I also see people trying to find the energy and commitment to carry on. Come up with new solutions which hinge on collaborating at a local level - for that is where the fights will be now – and find ways of reaching people who haven't been reached yet. But I'm jumping ahead by a movie or two: back to the huddle point.

How do you turn this around? Anger is more useful than despair. At the process, not each other. At the **Telegraph** spin piece which brazenly claims "the NHS needs replacing". At the monumental suffering that is being caused within general practice by the monstrous denial of the nature of the problem. At government ministers who boldly claim the NHS is "failing them" for not carrying out procedures in a walk-in clinic that an A&E department would (clue's in the name, Michael: "hobble in" isn't above the door...). The list grows daily.

How do you stay angry? A few people have managed that by staying angry

with each other. That's misdirection. This is perhaps understandable as the goal posts shrank. Much of the campaigning was election focused and the wrong result was a frustrated goal. With the disappearance of that common aim, and the lack of any vision to take us beyond it, it becomes too easy to start picking fights with each other.

I see hope in taking the longer view again. Where is the real enemy? What can we do to take the fight to this enemy at the local level? We need more people – how do we get them?

I was encouraged to witness the arrival of at least two groups after the election who had NHS privatisation as an aim. GP Survival and NHS Survival are small, high-profile groups with a couple of noticeable differences to the more established ones. First of all, they appear to be made up largely of people who are new to this, as a rule. Second, these campaigns are geared to social media.

That last point is exciting. Because it reflects a growing truth, which is that political campaigns must utilise these newer forms of communication if they are to reach the groups of people they have not been reaching in other ways. And some of the more established groups have not been engaging in this way greatly as yet. Ours included.

This does not mean that Facebook and Twitter are the answer. They are just a part of it. But they are a part we need to recognise more. So the movement has not ground to a halt: other solutions, other ways of carrying it forward, are becoming apparent.

They work, for anyone, with a little planning and skill and a touch of motivation. Get up!

There is, also, an encouraging truth for Doctors for the NHS. Which is that the group has a vital role to play in this. There are few more encouraging sights than seeing a doctor who agrees with you in saying that the NHS is under threat. People warm to that. It also happens to be right. This group has expertise, gravitas. It can appeal uniquely to other doctors on a peer level. Its strengths are key in overcoming despair.

So I see the way out of despair for our movement. Getting all the groups to agree will be difficult. But if DFNHS can be there, giving the expert view, that is an immense strength. Other groups will warm to it.

I'm not suggesting DFNHS members start picking up campaigners by the throat. But telling them anger is more useful than despair (dodgy accent optional) has to be a good thing. For the good thing we all want: an end to this threat. We'll be back.

Alan Taman
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New Kids on the Block

Newcomers welcome. With a blaze of national publicity, NHS Survival hit the headlines in August (www.nhsurvival.org) .

The latest group to join the fight to save the NHS has taken a distinctive stance politically, by declaring itself to be "neutral" on the quesiton of seeking a political solution to NHS privatisation.

The key for them is to establish a Royal Commission to look at the following:

- To ensure a long-term plan is made for funding safe, sustainable 7-day services throughout the NHS.
- To ensure care continues to be safe, appropriate, and tailored to patients' need.
- To ensure the NHS remainsrepresentative of and accountable to patients.
- To ensure the NHS continues to recruit and retain sufficient numbers of motivated staff so the NHS is kept safe.

They are, like their "sister" organisation GP Survival (www.generalpracticesurvival.com) geared to voicing and engaging via social mediia, principally Facebook and Twitter. GP Survival's principal spokesperson is GP Zoe Norris, who blogs for the **Huffington Post.**

DFNHS is in contact with both groups .

The AGM and Conference 2015

will be held on Saturday 3rd October at Bedern Hall, York

Full details and application forms were sent out to all members in August.

If any have gone astray, been lost etc , duplicates can be obtained from the address below.

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Book Review:
Change Everything: Creating An Economy for the Common Good

Christian Felber. Zed Books. £12.99

Christian Felber is an Austrian alternative economist and a very successful activist. His book was originally published in German in 2012, the (good) English translation was published in 2015. The movement Economy for the Common Good was launched in 2010 and now numbers 1,750 "supporting enterprises" in 35 countries and 220 "supporting organisations". An international association is in the process of foundation.

Susan George, the author of Whose crisis? Whose Future? commented "Christian Felber has written that rare article: the genuine game-changer. Easy to read, irrefutable in its principles and comprehensive in its proposals, it's a how-to guide to a better world. Don't miss it. Felber describes ten "crises of capitalism", the consequences of the pursuit of profit and competition rather than cooperation. The ten crises are: the concentration and misuse of power; the suppression of competition; the building of cartels; competition between locations; social polarisation and fear; failure to satisfy basic needs and reduce hunger; ecological destruction; loss of meaning; the erosion of values; and the shutdown of democracy.

Felber proposes a fundamental overhaul of our capitalist system. Companies still earn profits but they are driven by their "Common Good balance sheets" which assess them in terms of how cooperative they are with other companies, whether their products and services address human needs, whether they are environmentally responsible and how humane their working conditions are.

There are 21 rich pages of "real world examples" covering 15 organisations including John Lewis – "a role model for employee ownership". An appendix gives a useful 20-point summary.

Peter Draper