NHSCA

EDITORIAL December 2013

The wider context

"… the coalition government took the decisive steps in helping to turn some first-rate universities into third rate companies". Stefan Collini [1], professor of English at Cambridge University.

Towards the end of the 1980s a set of neo- liberal policy principles emerged which gained governmental support across continents. In 1990 the economist John Williamson called these principles "the Washington Consensus". They are fiscal discipline, reordering public expenditure priorities, privatisation, deregulation, tax reform, liberalising interest rates, a competitive exchange rate, trade liberalisation, liberalisation of inward foreign direct investment, and property rights.[2] The Washington Consensus remained a statement of "market fundamentalism", the view that markets solve most, if not all, economic problems by themselves.

Sainsbury[2] points out that for the period 1980 to 2000 the developed world suffered a decline in growth of per capita income from 3% to 1.5% and that there was a similar decline for developing countries. Exceptions were Korea and Taiwan which both relied heavily on public investment and made use of industrial policies such as a directed credit, trade protection, export subsidisation and other interventions of the sort deplored by the World Bank and the International Monetary Fund. In comparison countries in Latin America such as Mexico, Argentina, Brazil, Colombia and Bolivia and Peru did a great deal of liberalisation, deregulation and privatisation, and Latin America's growth rate remained a fraction of its pre-1980 level. The UK has seen decades of neglect of the country's productive base and an over reliance on North Sea oil and financial services.

Two types of capitalism can be described, one with collective working, consensus and long-term concerns while the neo-American model is based on individual success and short-term gain. A graph with employment protection on the Y axis and the degree of stock market capitalisation (i.e. reliance on financial services) on the X axis shows a clustering into two discrete groups. The top-left group with high employment protection and low stock market capitalisation includes Switzerland, Austria, Germany, Netherlands, Belgium, France, Finland, Denmark and Japan whereas the bottom-right group with low employment protection and high stock market capitalisation is comprised of the USA, UK, Australia and Canada. Which country, do you think, is the fairly extreme lower right outlier with by far the highest stock market capitalisation and second only to the USA in having the lowest employment protection? Why, the UK. The neo-American group uses market relationships in the form of arm's length exchange of goods and services in a context of competition and formal contracting (the NHS's purchaser-provider split, for example), whereas the first group relies on non-market relationships to co-ordinate their actions with others in the economy. In the UK the financial markets became increasingly dysfunctional[2] with a great deal of economic behaviour aimed to extract value from other participants in the economy without making any contribution to productivity. For example, investment managers cream off large sums of money to pay themselves monumental bonuses when those returns should flow to savers such as pension funds. Companies have asset managers seeking short term profit by trading shares and are no longer held to account in respect of long term growth.

The deregulation that led to the financial crash of 2008 cost the US economy $14 trillion according to a

former Harvard Law School professor specialising in bankruptcy law, Elizabeth Warren, who is now the senator for Massachusetts and a potential Democratic candidate for the 2016 presidential elections.[3] She writes that Wall Street CEOs wrecked the USA economy, destroyed millions of jobs and that they *"still strut around Congress, no shame, demanding favours and acting like we should thank them"*. Since the crash, the top US institutions are 30% larger than before, they own half the country's bank assets and are in receipt of an implicit taxpayer subsidy of $83 billion per annum. Warren states: *"People feel like the system is rigged against them. And here's the painful part: they're right. The system is rigged*".

In the UK in the last 30 years income inequality has increased and income inequality is associated with myriad adverse effects including lower life expectancy and raised infant mortality.[4] Nine million people are living below the bread line at a time when the chief executives of the UK's biggest companies are earning on average £4.3 million per annum, 160 times the national average wage.[5] In the USA the figure is 300 times.[2] Atos is using the "living wage" as a maximum rather than a minimum. Atos healthcare administrative staff may earn £16,000 per annum, whereas the Atos chief executive Thierry Breton received a 14% pay rise of £237,992 last year taking his wage and reward package to £2,329,250. In terms of growth of UK income, the richest 1% takes 24% of all growth leaving the bottom 50% to gain just 15%. Personal debt in the UK has reached £1.4 trillion with an average household debt of £54,000 which is nearly double what it was a decade ago. This has a corrosive impact on people and families and wreaks havoc with mental health, relationships and well-being.

Collini[1] in considering changes in British society from the 1980s points to a curious anomaly. On the one hand British business enterprises have a mixed record, frequently posting gigantic losses, mostly failing to match overseas competitors and scarcely benefiting the weaker groups in society. On the other hand public institutions such as the universities, the BBC, museums and galleries have by and large a very good record with universally acknowledged creativity, advancement ahead of international peers, positive effects on human development and promotion of social cohesion. Nonetheless over the past three decades politicians have repeatedly attempted to force the second set of institutions to change so that they more closely resemble the first. Historians may wonder why there was so little concerted protest at this deeply flawed programme.

A government that denigrates the public sector is liable to deliver it to big business. UK outsourced public services are estimated to be worth £100 billion with contracts heavily weighted in favour of a handful of private companies. There is little transparency and accountability. The Serious Fraud Office has now launched a criminal investigation into two of the government's biggest suppliers, G4S and Serco, following claims of tens of millions of pounds of overcharging on electronic tagging contracts for offenders. An external audit revealed that the overcharging included billing for tracking the movements of criminals who had moved abroad, who were back in prison, who had had their tags removed or who had died. Whitehall sources have confirmed that the central allegation in the case revolves around charges for 3,000 phantom offenders: the correct total was 15,000, not 18,000. Private healthcare companies have made more than 300 donations to the Conservative party and over 100 Tory peers and MPs have connections to private healthcare companies. One estimate is of £5 billion of NHS expenditure now going to the private sector, and rising. There have been calls for the re-nationalisation of the railways, gas, electricity and water and in general an increase in the proportion of public versus private enterprise.

The Archbishop of York John Sentamu in an address on 19.11.2013 to the general synod urged Anglicans to emulate the architects of the welfare state. *"They had a clear vision as to how things could be different. In part they were also tapping into the spirit of the immediate post-war years in which there was a great hunger to rebuild a more equitable world. It is that vision which we need to recapture today"*.[5] More generally, there is a crying need to abandon the neo-liberal ideology which has paralysed economic thinking for the last 30 years.[2]

MORRIS BERNADT

1. Stefan Collini (2013). Sold Out. London Review of Books. Issue 24.10.2013 vol 35, pgs 3-12.
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4. Richard Wilkinson & Kate Pickett (2010). The spirit level. Why equality is better for everyone. Penguin books, London.
5. Sam Jones (2013) Poverty and hunger in the UK are a disgrace to us says Sentamu. Guardian newspaper 20.11.2013.
6. Alan Travis (2013) Serious Fraud Office launches inquiry into G4S and Serco overcharging claims. Guardian newspaper. 4.11.2013.

Future Hospital Commission

Michael Rawlins
(Professor Sir Michael Rawlins, Chair, Future Hospital Commission)

The Royal College of Physicians published the report of its independent Future Hospital Commission[1] in September this year. Although the report represents the conclusions of the Commission itself, it is based on the findings of the 5 Work Streams that played a critical role in developing the final recommendations.

Background

The Commission was established in response to the College's 2012 report *Hospitals on the Edge*[2]. Most, if not all, members of the NHS CA will recognise the intense pressures that are placed on hospital services in attempting to provide acute medical services. In summary they comprise:

1. Increasing clinical demands with a 33% increase, in the last decade, of emergency admissions; and this in the face of a third fewer general and acute beds, now, than there were 25 years ago;

2. The changing needs of acute medical patients with those over 65 years of age – and with multiple conditions – predominating;

3. Poor continuity of care that too many patients receive when admitted to hospital;

4. Inadequate arrangements for out-of-hours care with a 10% increase in mortality at weekends;

5. A looming workforce crisis amongst both consultants and trainees. Three quarters of hospital consultants reported being under more pressure now than three years ago; and over a quarter of medical registrars reported an unmanageable workload.

The Future Hospital Commission

The Commission was established in March 2012. It brought together patients, fellows of the Royal College of Physicians, and experts in healthcare from many other disciplines including surgery, anaesthetics, intensive care, general practice and NHS management. The Commission's goal was to construct a vision of what comprehensive high quality medical care for patients could (and should) look like. The Commission established 5 Work Streams to examine the problems and potential solutions in greater depth:

- People
- Place and Process
- Data
- Planning and infrastructure
- Patients and compassion

The Commission's final recommendations therefore represent the collective wisdom of more than 150 individuals.

Recommendations

The Commission's recommendations can be conveniently divided within four groupings:

- Culture
- Process
- General internal medicine
- Consequential conclusions

1) Culture

The Commission was not established in response to the Francis Report on the failings at Mid-Staffordshire Hospital. Nor, for one moment, did Commissioners believe that NHS staff, as a whole, lack compassion for the patients under their care. Nevertheless the report emphasises that the principles of appropriate patient care should place as much value on a patient's experience and compassion as on clinical effectiveness. The Commission considered that the essential ingredients of care comprise dignity, compassion, confidentiality, and privacy. Furthermore, a named consultant should be ultimately responsibility for patients' and their care plans. Taken together, these features underpin all the recommendations in the report.

2) Process

The Commission's report sets out a radical new model of care designed to encourage collective responsibility for the management of patients across professions and healthcare teams. It proposes new ways of working between hospital and community, supported by financial and management arrangements that give greater priority to caring for patients. Thus, care should come to patients and be coordinated around their needs, wherever they are, obviating the trend for patients, particularly older ones, to move beds several times during a single hospital stay. This is

known to result in poor care, diminished patient experience and prolong length of stay. Delivery of specialist medical care, such as cardiology or neurology, should not necessarily be limited to patients in specialist wards or to those who present at hospital. Specialist medical teams should work across the system 7 days a week.

To deliver this vision the Commission proposes the establishment, in general hospitals, of:

- a Medical Division;
- an Acute Care Hub
- a Clinical Co-ordination Centre.

The Medical Division should be responsible for all medical services across the hospital. It should assume clinical, managerial and budgetary responsibility for all inpatient beds and clinical areas supporting the care of medical patients (with the exception of those aligned to paediatrics, obstetrics and specialist surgical wards). For large hospitals it is envisaged that the Medical Division will be an overarching structure inclusive of several specialty medical directorate services. For small hospitals it might align with an existing single medical directorate where this already includes specialty medical services such as cardiology, respiratory medicine etc.

The Division of Medicine should be led by a "chief of medicine". He or she would be an experienced physician, reporting professionally to the medical director, and leading all medical specialty directorates/services as well as coordinating their activities in delivering medical care.

The Acute Care Hub should bring together the clinical areas of the Medical Division that focus on the initial assessment and stabilisation of acutely ill medical patients. These include the acute medical unit, the ambulatory care centre, short-stay beds, intensive care unit and – depending on local circumstances – the emergency department. The Acute Care Hub will focus
on patients likely to stay in hospital for less than 48 hours, and patients in need of enhanced, high dependency, or intensive, care.

An acute care coordinator will provide operational oversight to the Acute Care Hub, supported by the Clinical Coordination Centre, liaising with the community-based parts of the system including social; services.

The Clinical Coordination Centre will be the operational command centre for the hospital site and Medical Division, including medical teams working in the community. It will provide healthcare staff with the information they need to care for patients effectively. It will hold detailed, real-time information on patients' care needs and clinical status, and coordinate staff and services so that they can be met. In the longer-term, this would evolve to include information from primary and community care, mental health, and social care. This information would be held in a single, interoperable, electronic patient record,

The Commission believed that it was critical for the most modern advances in medical care to be available all patients, whenever they need it, whatever their additional needs, and wherever they are in hospital or the community. This means specialist medical teams will work, not only in specialist wards, but across the hospital. A single named consultant will coordinate care for patients with multiple conditions, with input from a range of specialist teams as necessary.

3} General internal medicine

The Commission believes that all physicians should be trained in, and continue to practice, general internal medicine for most (and possibly all) their professional careers. This is not intended to belittle, in any way, the contributions that specialists make to the care of patients with a wide range of conditions. Rather, it recognises that increasing numbers of acute medical patients present with co-morbidities that require holistic care.

The Commission recognises that this will take time to achieve. A physician who has practised solely in a specialist role for many years cannot possibly be expected to "re-train" in general medicine. Nevertheless, the Commission recommends that, in the future, all trainees combine training in general internal medicine as well as in a speciality. It also means that, in the future, the practice of general medicine should carry with it same "kudos" that is currently held by specialists. This is discussed in greater detail below.

4) Consequential recommendations

For the Commission's vision to be fully realised there are a number of consequential recommendations:

- education and training
- research agenda
- electronic health records

As already discussed, the Commission believes that dual training should be the norm across the physicianly specialties with participation in general internal medicine being mandatory for those training in all medical specialties. The Medical Division should assume overall leadership and responsibility for promoting the development of general internal medicine and chronic disease management and multi-morbidity.

Medical divisions should also consider developing the position of "chief resident" within all acute hospitals. The chief resident, a trainee doctor, would act in a liaison role between medical staff in training who are working in
the Medical Division and the chief of medicine and senior clinical managers. This leadership development post would have a key role in planning the workload of medical staff in training, medical education programmes and quality improvement initiatives.

There is an important *research agenda* for general internal medicine. In general clinical trials of new interventions are carried out amongst very homogenous populations and usually in patients with single conditions such as heart failure, chronic obstructive pulmonary disease (COPD) or hypertension. While there may be good reasons for such "proof of principle" studies, in reality, patients with acute medical conditions rarely have such single conditions. Thus, in a patient with heart failure who also has COPD, is it appropriate to prescribe a beta-blocker for the heart failure? Or will this exacerbate the symptoms of COPD? Or should the patient be treated with an oral beta-blocker and an inhaled beta-agonist? Or neither? There are numerous similar problems in the management of patients with co-morbidities; and their solution requires novel approaches to clinical research.

Bringing together information about patients' past and present clinical information, encompassing both primary and secondary care, will require the development of, widespread access to, electronic health records (EHRs). The NHS's track in delivering EHRs, especially in secondary care, is dismal; and the Commission's report wills the ends but not the means. It is though incumbent on us all to promote EHRs, with real time decision-support tools, if we are to do our best for our patients.

Implementation

The Commission accepts its report is a blueprint. Not all its recommendations will be appropriate for all hospitals and health economies. And although some of its proposals can be implemented rapidly (the establishment of a Medical Division and the appointment of Chief of Medicine for example) others (such as expecting all specialists to combine their specialism with general medicine) will inevitably take time to achieve. Nevertheless, it is a direction that we must follow if the NHS is to provide patients with the care they deserve.

References

1. Royal College of Physicians. *Future Hospital Commission: Caring for Medical Patients*. Royal College of Physicians of London: London 2013.

2. Royal College of Physicians. *Hospitals on the Edge? A Time for Action*. Royal College of Physicians of London: London 2012

Membership

The message below was emailed to our members in mid November and we are grateful to those who responded in various ways enabling us to bring the Association, its aims and purpose, to the attention of our younger colleagues who will be working in the NHS for many years to come.

Dear Colleagues
As you probably know, we do invite Registrars/Specialist Trainees to join as Associate members at a lower rate of subscription. We discussed at our EC yesterday the need to reach more of them with the invitation but they are much harder to locate than consultants, who can be found on hospital lists in various ways.

We would be most grateful therefore if those of you still in active practice could email us the names and specialties of any working in your hospital. We will then send them an information pack but not mention the source of the information unless you so request.

With thanks
Peter Fisher

As at present we only have functioning email addresses for just over half our members the message is repeated here for the others, whose help we would appreciate (and if we could have an email address for future use, that would be even better!)

The AGM and Conference 2013

Reports presented at the AGM appear below, followed by those recording the Conference sessions and the Paul Noone Memorial Lecture.

The minutes of the AGM are available to any member on request, electronically or in hard copy.

The Executive Committee for the coming year was elected and the list of members, together with their contact details, appears elsewhere in this Newsletter.

Co-chairs Report to the NHSCA

This year has been another very busy year for the NHS in every sense. The legislation of the Health and Social Care Act, (including the section 75 regulations) has clearly resulted in the acceleration of the privatisation process, with the majority of new contracts going to private providers rather than the NHS. Many CCGs are clearly worried by the legal implications of not putting services out to tender, hence most are taking the safe option by tendering. Since private sector companies have such expertise in this field, they seem to be winning contracts over the NHS hands down at present. One bright ray of sunshine was the recent decision by the Wyre Forest CCG not to put local community health services out to tender, and keep their local NHS contracts. Other CCGS needs to be encouraged to follow suit.

The Francis, Berwick and Keogh reviews have clearly highlighted that there are genuine and significant, deep seated problems in some parts of the NHS, which must be addressed. However, with so many conclusions and recommendations, it was easy for the Government to set out its own narrative of what needed to be done in response. The media also took its own view, which has resulted in many bad news stories about the NHS, including the infamous "NHS kills 13,000 patients story". This has undermined public trust in the NHS, which clearly risks more softening up for further privatisation. It also makes things more difficult for doctors, as it can lead to the undermining of the doctor-patients relationship, where trust is absolutely crucial. We believe that key messages from these reviews and reports have been glossed over, ie management structures obsessed with financial targets and business principles, low staffing levels, and the culture of fear in the NHS. The NHSCA clearly needs to make the case that medical professionalism, clinical leadership, and transparency are crucial to maintain safe and effective care, but that this is almost impossible in the environment of a market driven system, which undermines professional values, the public service ethos, and makes openness more difficult. We need to embrace the culture of openness and get involved in providing high quality data to look at our clinical outcomes, but we need the clerical support and clinical time to do this. Producing high quality and meaningful clinical data doesn't come cheap!

Patient safety will be further compromised by the £30-50 billion financial black hole that is expected by 2020. The Government cannot expect to continue to with their "More for less" approach to the NHS. The more that is cut, the harder it gets. We have already seen the consequences of this with the current A+E crisis, which has prompted HMG to find an extra £250m per year for two years (from other parts of the NHS budget!). The scandal is that the Treasury has clawed back £3billion of the NHS budget in the last 2 years on top of the QIPP efficiency savings programme. Not surprisingly, this winter is already looking bleak for the NHS, with some hospitals enduring summer bed crises. There is clearly a national shortage of beds, and a lack of community and social care facilities to deal with "bed blockers". Meanwhile the policy wonks are suggesting that 25% of hospital patients should be managed in the community – so where is the plan to deliver these community services? There isn't – this government don't do planning, they do markets.

This winter could be a watershed moment for the Government. Public anger is already welling up and NHS campaign groups are making slow, but steady progress in raising public awareness about what is happening to the NHS. Over 50,000 people marched in Manchester (including many NHSCA members), and although the media coverage was once again very poor, it sent a clear signal to the Government, that the tide of dissatisfaction is continuing to rise. A failing NHS is necessary to accelerate the privatisation process, but it is also electorally very damaging. The Government is going to find itself in a very sticky situation on the NHS at the next election.

Yet another very worrying development is the announcement from health minister, Norman Lamb MP, that he would like to see the mutualisation of NHS FTs. This will be dressed up as NHS staff "owning" and taking "control" of their hospitals. However, this is yet another step towards privatisation. If

this policy is forced through, then we must ensure that "asset locking" is guaranteed, otherwise, large chunks of the NHS could be sold off to large private healthcare companies.

On the wider political front, austerity is this Government's political prescription for managing the economy. Since austerity has clearly been shown to worsen public health (please see Basu and Stuckler's fantastic book, "The Body Economic") this will only continue to increase the demand on a system, which is financially under huge pressure. The NHS will therefore continue to hit the headlines, and the NHSCA needs to be there to explain that there are alternatives to the expensive and wasteful healthcare market. We need to keep the campaigning going, but more senior doctors need to come out in support of the NHS. Too many are sitting back and accepting the inevitable. But our NHS is too important not to take a stand and fight for. Please start raising these issues with colleagues and encourage them to get involved.

So not much good news to report. Add in the pension changes, changes to CEAs, and the potential abolition of incremental pay rises, and it gets worse!
However, to end a more positive note, it has been wonderful to see the success of the book "NHS SOS", co-edited by our very own Jacky Davis! It has sold very well (on 4th reprint), and has had great reviews. It has been well advertised on social media and we encourage all our members to read it. (All profits go to Keep Our NHS Public).

The truth of what is happening to our NHS must be told. It is the only way to save it.

CLIVE PEEDELL
JACKY DAVIS

HONORARY TREASURER'S REPORT
FOR THE AGM OF THE NHSCA
Saturday 12th October 2013
Bedern Hall, York

In contrast to last year I have been doing my best to emulate our beloved Chancellor by refusing various requests for NHSCA funding support. Obviously for us to continue to function effectively some projects have had our financial backing. These included our support for a report on the attempts to reorganise London Services –in particular the plan to close/ downgrade Lewisham Hospital A&E. We also supported the NHS Fed's project to have a central data-base of the effects of the cuts and Privatisation Act on the NHS. Despite my best efforts for a third year in succession we have shown a year on year deficit although that is now at a containable level. Despite our President's heroic efforts recruitment remains at a lowish level. Our Subscription Income is statistically unchanged.

As ever, we owe a debt of thanks to our Auditor Mr Bob McFadyen who has, once more, kept our accounts in impeccable order as witnessed in his accompanying report.

This year's accounts show that we outspent our income by £1,264.39 thus lowering our reserves a little further. We continue our funding of KONP with a quarterly donation amounting to £8,000.00 annually. As explained above the NHS Fed received more than usual with our funding of a specific project.

All this means that we can continue our regular support for both KONP and the Fed at the regular level and have some extra to finance specific one off developments

The following points will help clarify some of the issues arising from the accompanying audited accounts:-

1 Due to the heroics of those attending the 2012 AGM/ Conference in London an extra £545.00 was raised in donations beyond the delegate fees. Thus the deficit was kept down to £141.00. Our intention in using York as the venue again this year is that the support from the Association for this event will remain at a low and sustainable level. It must however be kept in mind that having the Conference in London is vastly more expensive and will run the risk of eating further into our reserves.

2 The Committee Travel costs inevitable fluctuate depending on who is able to attend from the wide geographic representation of the membership on the EC. This year it was lower than previously but it will always be highly variable.

3 The fact that postage costs have actually decreased is down to our President using a franking system which has largely offset the huge increase in postal charges last year.

Unfortunately I am unable to attend the AGM this year but will deal with any questions that cannot be answered by other Committee Members subsequently.

JONATHAN DARE
Honorary Treasurer, NHSCA

KONP Report

Steering Group
The steering group has met every month apart from August at the RMT offices. We are very grateful for this facility as accommodation in London is expensive. Local group representatives have been a great addition to the Steering Group and were glad to have Gilda Petersen from Leeds and Anna Ridehalgh from Southampton on a few occasions. From affiliated groups, Peter Fisher (NHSCA) attends regularly as does Barrie Brown from Unite... We were all saddened by the death of Harry Keen (NHSSF) in April-he had attended the steering group regularly until October and he did not tell us of his illness until the month before he died.

Personnel
Adeline O'Keeffe has continued as campaign manager working about half the week and has done a brilliant job despite her caring responsibilities. Helen Cagnoni works one day a week on finance. Hannah Russell worked on a project basis, updating the database and preparing the new KONP campaign newspaper and Patrick Griffin on the arrangements for the AGM. Camilla Giambonini started on July 1st as an administrative assistant after a short time as a volunteer. Wendy Savage resigned as co-chair in April and has been replaced by Sue Richards, a retired Professor of Public Management... The steering group decided to create the post of President for Wendy Savage. The office has moved to Hackney although finance is still dealt with at Vincent Terrace, and it remains the postal address for KONP.

Website *www.keepournhspublic.com.*
Paul Lister continues to maintain the website (free) and gives invaluable advice for which we are very grateful. He helped Adeline to set up the computer in the Hackney Office. We have continued to pay Anna Macfarlane in Dundee and Matt Shapiro in Leeds to trawl the press to update the website.

Finance - 2012.
NHSCA have given us a quarterly grant of £2000 for which we are very grateful as we are to Unite for their £2500 a year. Our income reached £60,000 in 2012 thanks to grants from the Andrew Wainwight Trust and the Network for Social Change. The monthly standing orders hover around the £1200 mark which pays for media trawl and financial management. Thanks to all those individuals who are contributing regularly. The Andrew Wainwright Grant was used to pay Caroline Molloy to write guides dealing with the Health and Social Care Act. The first £5000 grant from the network for Social Change is being used to employ a fundraiser Liberty Smith who has managed so far to raise a further grant of £5000. The larger grant of £15,000 was to employ an administrative assistant so that Adeline can spend more time on the strategic aims of KONP and for accommodation so that the office could be established in Hackney.

The AGM on 13.7.13
This was held a new venue the Hinde St Methodist Church off Marylebone High St in London. It was very successful with over 100 attending. Polly Toynbee,The NHS, the media and campaigning, and Jacky Davis, The next 2 years, both gave inspiring speeches and we ended the afternoon with a song from the Liverpool Socialist singers led by Alex Scott-Samuel. The only glitch was that Linda Kaucher who spoke about the EU/US Trade agreement over the lunch break, overran, so the KONP groups who had prepared to give short presentations to explain their displays were unable to do so. Our apologies to them.

Parliament. In Parliament we worked hard to try and mobilise the Lords to defeat the section 75 regulations in February and April 2013. We may have influenced the withdrawal of the first set of regulations, which contained clear and unequivocal instructions to CCGs to put services out to tender. These were replaced by another version, which may offer scope for delay and resistance for those CCGs who wish to follow this path. There is much scope for litigation and until case law becomes established the route to commercialisation is not straightforward. We wrote to LibDem and Crossbench peers and the Bishops arguing that they should oppose the regulations. A motion put by Lord Hunt of Kings Heath to kill the regulations failed by a majority of just over 100... We also wrote to the Presidents of Royal Colleges and received two replies from RCOG and RCS. Our thanks to Eileen Smith, Frances Hook, Shirley Murgraff, Alec Gordon, Shirley Gibb, Paul Johnson and Helen Cagnoni who helped to stuff envelopes.

Related activities. We have attended meetings of the Faringdon group and those called by the SHA and the launch of David Owen's bill to restore the Secretary of State's responsibility for the NHS We have sold over 40,000 postcards for people to

give to their GPs saying they do not want private referrals. Another edition of the newspaper was published on12.07.13 and a copy put in each of the AGM conference packs. You can order via the website £12 for 20 or £50 for 250 including P&P.

Membership. The good news is that we have had three new groups launched formally, Ryedale, Tameside and Wakefield. We now have 35 active KONP groups in England and one inactive in Wales. Communication has been primarily to local and affiliated groups, as contacting individual members has been very time-consuming to make contact. This problem has just been sorted out and we aim to do much better in the future.

Working with the BMA. At the Annual Representative Meeting (ARM) in June 2013 Jacky Davis who is on the steering group proposed the Islington Division motion of no confidence in Jeremy Hunt which was passed, as were two other motions condemning the H&SC Act in general and Section 75 in particular which were passed with large majorities. The new chair of Council spoke against the H&SC Act.

Demonstrations and conferences. At a TUC demonstration on 20.10.12, the RMT paid for a KONP 'giant' balloon, which June Hautot organised. Several people ran a KONP stall. There was a large KONP contingent quite near the front of the march. The balloon was also used in Manchester and when we organised a demo outside the House of Lords on 24th April, to coincide with the debate over Section 75 Regulations. The most recent demonstration was organised outside the BBC by Fran Hook and Eileen Smith on 4 July, to protest against the BBC's poor coverage of NHS issues. A letter on behalf of KONP to the Director General from Sue Richards was delivered on the day.

With the attacks on the South London Health Care Trust and subsequent effect on the Lewisham Hospital and proposed closure of A&E departments, individual KONP members have attended numerous demos in Brent, Ealing, Lewisham, and Greenwich. Louise Irvine a GP who started the Lewisham KONP is chair of the Save Lewisham campaign. We were delighted by their success in the High Court in August.

The People's Assembly. KONP was an original signatory to support the creation of a People's Assembly, which took place in June. We ran a session attended by over 1000 delegates where panel speakers were John Lister, David Wrigley, and Gill George and Norma Dudley and Wendy Savage was in the chair. A highly successful stall was run by Paul Johnson. Almost 100 copies of the book NHS SOS, edited by Jacky Davis and Ray Tallis, were sold on the day

Speaking engagements. Wendy Savage has addressed meetings in Charlton, Brighton at two TUC fringe meetings, Oxford, Sheffield, Petersfield, Unite the Resistance Conference London, Hampstead, Birmingham and Plymouth., Others have also spoken on behalf of KONP including Peter Fisher, Jacky Davis and Colin Leys and Adeline O'Keeffe spoke to the Bevan Society..

Letters to the Guardian or articles from Jacky Davis, Peter Fisher. Colin Leys, Peter Draper, David Wrigley, Sue Richards and Wendy Savage have been published and do generate interest via the website.
Our Facebook group has grown but not dramatically and Suzy Condrad, Jacky Davis and David Wrigley has been tweeting for us on KONP's behalf.

WENDY SAVAGE
President

The next year

During the next year, several key issues are likely to be important

- The impact of the 2012 Act and Section 75 regulations will be felt in practice. We need to use our local knowledge and networks to gather information about this, and make it available on the national stage and to help other existing and potential KONP groups. We need to ensure that there is public knowledge about any vested interests involved in decisions to use competition, the track record of those who win contracts, and information about their performance.

- The EU US trade negotiations have just started. This spells real danger for the NHS as we have known it, and there will be no going back once the agreement is tied up. (See separate briefing about this). We need to campaign for the NHS to be exempt from the provisions of this treaty

- The next general election campaign has already started. We have a big role in ensuring that the commercialisation of the NHS is a major issue, and that people are mobilised to defend the

NHS through the ballot box. This starts with a major national demonstration in Manchester on 29 September at the Conservative Party Conference

What does this mean for us? How can we raise our game?

- We will have to get much better at communicating with each other and making use of the knowledge that we have within our network.
- We need to get better at both national and local level in using the media and work out how we can improve our effectiveness
- We need an effective political strategy in advance of the general election. We are party non-aligned but we need to develop an agreed approach to the next election campaign.
- We need to improve our coverage across England as a whole – more KONP groups and more members.
- We need to raise more money so that we can increase the effectiveness of the service offered by national KONP

SUE RICHARDS
Co Chair

Report to the NHSCA AGM 2013
NHS Support Federation

Earlier this year we launched a large project to collect evidence about how the NHS is being affected by the Government's controversial NHS changes. We set out to organise this emerging information into a database and to publish it online. A new website - www.nhsforsale.info. was designed specifically to attract users to access and contribute. The need for this resource was one of the important recommendations of last years AGM of the NHSCA. Since then we have been pleased to receive support from the NHSCA and a small group of other funders who have helped to get this important project up and running.

One of our first steps was to record details about the stream of new NHS contracts being put before the market. This meant we could publish data showing that over 200 clinical contracts worth around £2.5bn had been instigated since April. We established that diagnostics, mental and homecare were the leading targets for outsourcing and shockingly that, so far around three quarters of the contracts awarded have gone to the private sector. These findings were the first in a series of regular contract reports that we plan to publish. Media interest has been strong including coverage from the Guardian, Mirror, BMJ and by the Radio 4 Today programme.
By monitoring privatisation we can provide early warning alerts, so that news of tenders can be spread to campaigners and trade union members to help them respond. We also pass information about new contracts to journalists and this led to a front page article in the Guardian exposing the huge £1bn contract opportunity to run community services in Cambridgeshire.

In a similar way we have collected information about the leading private health providers, by maintaining profiles of their activities, political connections and business record. These profiles have been used by the media in articles by the Mirror and Express newspapers, outlining the problems with the GP out of hours service provided by Harmoni and Serco. This research will also be shortly published by the TUC analysing the low tax payments of some health companies.

A team of researchers, many of whom are volunteers, help us to collect and analyse a whole range of data. They help maintain a database of evidence about the impact of the act made up of reports, articles and personal accounts. It is available online and is themed around the original criticisms of the Act. The site also supplies the public with somewhere central to leave intelligence about what's happening in their own area.

We publish regular health briefings based on the evidence that we are collecting and target them at the media, politicians and list of around 10000 health supporters

Creative graphics and presentation now form a big part of our strategy to advertise the key facts and arguments, which has helped to open up large new audiences through social media like Twitter.

We have worked with Open Democracy, 38 degrees, unison, unite and Keep Our NHS Public in campaign work over the last year. Most recently carrying out research for Unite highlighting the political importance of the NHS in deciding the top Conservative marginal seats at the next election.

For more information about our publications and campaigns please take a look at our two websites www.nhscampaign.org & www.nhsforsale.info.

The passing of our founder and president Harry Keen earlier this year was a sad moment for all of us. He has made a huge contribution to defending the NHS. We will continue to draw on the inspiration that he provides and to fight for the NHS and the important values that it stands for.

Thank you to the NHSCA and to all its members for the tremendous support that you have given us over the last year and we look forward to continuing to work together.

PAUL EVANS
Director

Session 1: What should the future NHS look like?

This session consisted of three short presentations with audience participation.

David Nicholl (Royal College of Physicians Council member) discussed the dilemma faced by the Local DGH when some healthcare services are inappropriately transferred to "Centres of Excellence".

Paul Hobday (retired GP from Maidstone – who stood in at very short notice) looked at the problems facing GPs when hospitals "inappropriately" transfer some aspects of care back to the community.

Steve Goodacre (Professor of Emergency Medicine, Sheffield) examined the difficulties of providing a 24/7 Consultant Service.

There was considerable overlap between the components of this session. The bigger picture which has been developing over recent times has now been exacerbated by the 2012 NHS Healthcare Act, and compounded by the Administrators' crazy notion that secondary care still has 25% too many beds. Years of healthcare gymnastics have left us not knowing whether we are coming, going or been, and now unable to see how to execute a back somersault whilst performing a forward roll!

The RCP Future Hospital Commission has pledged that there should be no further reduction in hospital beds, and that hospitals should cooperate and not compete for services. It has identified necessary changes in clinical practice and hospital infrastructure but without seeing where the financial investment to implement these changes would actually come from.

We supported the transfer of care to "specialist" centres where there is scientific evidence of better outcomes, but cognizant of the research which demonstrated that when an ambulance carrying an emergency bypasses the local hospital, it may be adding risk not value to the clinical outcome*.

We recognised the adverse effects that the doctors who constitute the policy making bodies have

on services, by both consolidating their own departments and discouraging aspiring doctors from working in the sticks. Consequently the consultant skill mix in peripheral hospitals is being eroded. Furthermore, in most branches of medicine and surgery, there needs to be a reincarnation of the merits of being primarily a generalist with a special interest, rather than a specialist with little in the way of generalist skills. It is difficult to see how this would be achieved without rebadging the droves of Geriatricians that are now populating our hospital workforce.

We agreed that services should always be driven by quality not financial resources.

The relentless cheeseparing of local Clinical Commissioning Groups' (CCGs) budgets by the DoH, forces CCGs to identify Quality Innovation Productivity Prevention savings (QIPPs) to achieve the required level of austerity. In effect the NE Essex 2013-2014 budget of £420m, will be devalued by cost inflation and the need to serve a growing population without any real money from the Exchequer. This is how £20bn in real terms will disappear from the healthcare budget over the next 3 years.

We were given an example where Hackney CCG has outsourced its £1m Family Planning budget to a private contractor. Private contracts make it very difficult to challenge whether any improvement, let alone any deterioration, in quality had been achieved.

We considered continuity of patient care to be paramount, and recognised the way in which the European Working Time Directive (EWTD) has been responsible for destroying this aspect of care in hospitals.

Despite that, no one had a plan about how to rid us of this irrelevance!

Acute Psychiatric Care is now so underprovided that patients may have to be admitted to units hundreds of miles from their normal place of residence. David Nicholson, who was the architect of this black hole in psychiatric care, should be called to account and the Department of Health should be forced to unravel the devious web he has woven.

Many GPs are keen to provide care beyond their contractual core requirements, but are frustrated by the bureaucratic way in which they are required to attend and re-attend courses in order to comply with the regulations. Some of us felt that General Practitioners with Special Interests (GPSIs – pronounced Gipsies i.e. people who help you harvest your potatoes and then appropriate some of your livestock) should be phased out and returned to the role of hospital Clinical Assistants. Hospitals cannot expect GPs to take back the care of patients who have been prematurely discharged. There is neither the manpower in General Practice nor the facilities in the community.

Most GP surgeries are at breaking point and cannot take on additional work. GP vacancies in socially deprived areas are difficult to fill and those applying expect enhanced salaries. What about vocation?

Nursing Homes and Care Homes should pick up the bill if they call 999 before seeking medical advice from a doctor.

Rolling out Choose & Book, as a panacea for patients, has been grossly overrated. In some areas Referral Management Centres have been inserted between primary and secondary care. We abhor this practice!

It was agreed that the NHS should return to accepting the GP - Consultant relationship as the norm and the use of Choose & Book should only apply in special (as yet unspecified) cases. We felt that there were very few occasions where giving the patient a meaningful choice was actually followed by a better outcome.

The burgeoning numbers of patients referred to or who self-refer to Hospital Emergency departments is making it increasingly difficult to give adequate timely treatment to everyone. The 4 hour waiting time A&E target makes A&E a reliable choice for prompt treatment, particularly when the GP surgery is closed or when patients can't be bothered to make the effort to see their GP. Many A&E Departments are too small or understaffed to cope with this tsunami of minor illness and injury. This leads to increasing numbers of patients being admitted when additional time spent in A&E might have allowed the facilitation of discharge to their normal place of residence. Furthermore,

admission carries a higher PbR tariff and therefore an incentive not to discharge the patient home. However, with too few hospital beds available for emergencies, this means that patients may find themselves on wards that are inappropriate for their medical problems.

Short of rebuilding Emergency Departments and providing extra beds and staff (something that the hospitals cannot afford), the politicians need to have their noses rubbed in the s--- they have passed until they wipe up the mess and put in place (at their own expense) the deficient infrastructure and human resources. Currently the only answer from the DoH has been to offer more money to hospitals that fail the 95% A&E targets. This perverse strategy rewards "failing" hospitals that can then be short-changed by their local CCG for failing the same target!

Recruitment to the new-fangled speciality of Emergency Medicine is lagging behind the requirements necessary to deliver a 24/7 Emergency Service. It really is a no-brainer to think that Consultants will be prepared to work all the unsociable hours that God gave us until they reach retirement age. Let's first see if Lawyers would be prepared to devote such a service to their clients – at no extra cost!

What was wrong with having Physicians, trained in General Internal Medicine (GIM) with a speciality interest, delivering a 24/7 service?

The cynic in me says that it was the high flyers in those Speciality Silos that did not want their ranks expanded because it would have diluted their private practice!

Why have the Colleges promoted this policy? Because their committees are peopled by the very doctors that might lose out if the ranks of their specialties were expanded!

We found it very easy to cite examples of poor practice within the hospital service that have been the direct consequence of repeated political re-disorganisation of the NHS, but we came up with few workable solutions short of empowering the next Parliament to repeal the 2012 and the 2006 Healthcare Acts. To achieve this there would need to be an explosion of public outcry against the English NHS privatisation agenda.

Healthcare in Scotland continues to be delivered equitably without any of these shenanigans. The consequences of this nonsensical way in which healthcare is being delivered in England has to be pointed out endlessly in the media until the culpable politicians are shamed out of their parliamentary constituencies.

One of the drawbacks of using Bedern Hall for our conference is its poor acoustics. In some parts of the auditorium it was difficult to hear the full details of the questions asked or the answers given. This is also a reflection of our politicians' auditory apparatus. They fail to hear or understand what we are saying and invariably give responses which are off the wall!

* The relationship between distance to hospital and patient mortality in emergencies: an observational study.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464671/

MARK AITKEN

Session 2: Influencing the situation

Paul Hobday spoke about trying to influence clinical commissioning groups. He had been a GP in Kent who retired early because of the "dismantling of the founding principles of the NHS" and the implementation of the Health and Social Care Act. The CCGs have been allocated £65 billion to spend. There are 211 CCGs which are too small to make economies of scale. GPs have become the fall guys to take responsibility for the dirty work associated with the financial cuts to the NHS. GPs even get blamed for failures in secondary care. The majority of GPs do not wish to be involved. In West Kent there were 13 applicants for 12 CCG posts. GPs there are cynical and resent their time being taken up trying to interpret incomprehensible spread-sheets. There are fatuous meetings with some individuals taking the role of dictator. With NHS England interventions, European competition law, section 75 and Monitor, where is the so-called GP power? Some have fallen for the Lansley propaganda and do not realise that meaningful engagement is a falsehood. Amongst those GPs who do get involved, it is estimated that approximately 20 per cent have conflicts of interests associated with their own healthcare business interests which are liable to be facilitated by their membership of the CCGs.

GP budgets have been cut, large multinationals such as Virgin Healthcare have taken over GP centres and administrative costs have soared. These NHS changes have been the worst he has experienced in his lifetime. Zealots are castrating the public sector.

Deborah Abrahams's remit was to talk about influencing politicians.

She has been the Labour Member of Parliament for the Oldham East and Saddleworth constituency since a by-election in January 2011. Her previous career was as a public health consultant. She served on the board of Bury and Rochdale Health Authority and in 2002 was appointed chair of Rochdale Primary Care Trust. In June 2006 she resigned from this role, expressing her opposition to the use of private health companies in the NHS. The Health and Social Care Act is a very complex and poisonous piece of legislation, an act of privatisation of both providers and commissioners. A systematic review of health care provision she has been involved with produced no evidence in favour of these changes. On the contrary, they will reduce the quality of care. It is likely that they will lead to health insurance premiums. Private health care companies had donated £1.5 million to the Conservative Party and £1.5 billion worth of contracts has been awarded to these same health care companies. European Union competition law and the section 75 regulation have resulted in nearly all services being put out to tender, this despite parliamentary assurance that tendering would not necessarily be required. In respect of the Free Trade negotiations going on between Western Europe and the USA, Vince Cable has said that the NHS should not be exempt from the Free Trade Agreement. If this occurs every single NHS service will have to be put out to tender.

The widespread austerity and cuts to frontline services have resulted in an A&E crisis in the summer, let alone the winter. The reallocation of resources has resulted in reduced funding to poor areas and an increase to wealthy areas. Reduced local authority funding has been aggravated by personal health budgets and there has been an increase in the requirement for co-payments and top-ups. There's been a deliberate undermining of the NHS and extensive advertisement of poor practice to soften up public opinion for an attack on the concept of a free comprehensive service.

The Labour party is committed to repeal the Health and Social Care Act and this will feature in the Queen's speech of the first new parliament. There will be more vertical and horizontal integration of health and local authority care and a reduction of private care in NHS hospitals. Health and Well Being Boards will be retained. During question time Ms Abrahams stated that the Marmot recommendations (to reduce health inequalities) will be implemented in full.

MORRIS BERNADT

Monitoring the effectiveness and safety of the NHS - what does the future hold?

The Paul Noone lecture by Professor Sir Brian Jarman

What is the most effective way of ensuring safety in the NHS? Sir Brian quoted the advice given by the microbiologist, Paul Noone, to whom this lecture is dedicated, that hand washing is probably the single most important single factor and that safety can be markedly compromised by nurses having to work under great pressure because of financial cuts in the service.

This lecture described the development of monitoring of failure of care in hospitals in England. Twenty years ago this was initiated by a statistical unit at Imperial College. The development of a statistical index, the Hospital Standardised Mortality Ratio (SHMR) has allowed this major failure in monitoring of mortality in hospital medicine in England to be remedied.

The first major step in monitoring mortality was in 1977 when Sir Terence English introduced a Cardiac Register of Mortality.

In 1987 the collection of administrative data from hospital information systems of all patient admissions to all hospitals in England was started as a result of recommendations by a National Health Steering Group chaired by Dame Edith Körner. These data collections are large numbers of separate records, one for each period of care in hospital for each patient, and are called Hospital Episode Statistics (HES) or Körner data. They are stored in secure data warehouses. Prior to 1988 10% samples were used to estimate performance; after that date 100% of data was used.

In 1988 Professor Jarman was given access to HES data and produced a measure of adjusted hospital death rates. It was considered as a possible factor which could be used in development of a formula for the distribution of NHS resources according to need. This measure was the HSMR. The HSMR is the ratio of the observed to expected deaths, multiplied by 100, with expected deaths derived from statistical models that are adjusted for available case mix factors such as age and comorbidity. High ratios suggest that the deaths in a hospital are higher than expected by national death rates for age, sex, diagnosis etc.

The predicted risk of death can be calculated relatively easily from national or other benchmark data.

These variables are:

- Age group (<1, then 5-year bands to 90+)
- Gender
- Admission method / type (emergency, elective etc.)
- Admission source (home, transfers etc.)
- Deprivation quintile (based on postcode)
- Diagnosis subgroup (CCS sub-groups within each CCS group)
- Comorbidity (Charlson score)
- Emergency admissions in previous 12 months Palliative care (any episode that has a treatment function code 315 or any Z515 ICD10 diagnosis code)
- Ethnicity (white, mixed, Asian, black etc. - variable later dropped)
- Month of admission
- Year of discharge

Day cases are excluded from the risk models and include about 70 deaths / year.

The HSMR is an overall measure of adjusted in-hospital mortality and serves as a screening tool. Some of the deaths in the numerator will be preventable although many will be caused by factors not related to care and the HSMR cannot give the number of preventable, or avoidable,

deaths: it only gives the number of deaths above those that would be expected at the national death rates.

Adjusted hospital death rates were studied during the Bristol Royal Infirmary (or Kennedy) Inquiry. The children's cardiac surgical crisis at Bristol concerned major cardiac operations in children under one year old which were carried out at Bristol Royal Infirmary between 1991 and 1995. A Bristol anaesthetist felt the mortality was unacceptably high and reported on the situation to the Medical Director. The Kennedy Inquiry was convened. The adjusted death rate at Bristol for open heart surgery in children under one year was 29% between 1991 and 1995; it fell to 8% one year after improvements were made as a result of an external investigation by cardiac specialists; a further two years on it had fallen to 3%. The whistle-blower was ostracised.

Whistleblowing rarely occurred at this time as there was considerable reluctance on the part of the medical staff to report underperforming colleagues. Indeed in the mid 90's, a doctor who reported an underperforming colleague to the hospital chief executive was likely to be reported to the GMC and removed from the Medical Register whilst the poorly performing doctor continued to work.

An additional concern was that "Managers, who do not have an ethical or regulatory body equivalent to the General Medical Council, can report a doctor to the GMC, and even if the GMC finds no fault with the doctor's behaviour, the doctor may still find it difficult to get another job in the NHS."

The Kennedy Inquiry also stated that "the involvement of patients and the public must be embedded in the structures of the NHS and permeate all aspects of healthcare." Professor Jarman felt that the parents at Bristol should have been informed that the mortality at neighbouring hospitals was one third that of Bristol.

An article published in the BMJ (Aylin P, Bottle R, Jarman B, Elliott P. BMJ 2004; 329 : 825) showed that the SMR for the paediatric cardiac surgery at Oxford was very high. Sixteen cardiologists and cardiac surgeons wrote a letter of complaint to the GMC on 15 December. The letter stated:

"We ask whether or not Dr Aylin acted unprofessionally by bringing very harmful information into the public domain in this manner. We believe that he ought to have followed other clinical governance mechanisms. This would not have caused such harm to so many innocent parties including patients and families. He should have predicted that his conclusions would be contested by the paediatric cardiac community as a whole."

"The Case Examiners for the GMC referred to paragraph 35 of Good Medical Practice when making their decision. They considered that the publication of a scientific article in a major peer reviewed journal did not amount to a malicious or unfounded criticism of colleagues. They considered that the article was reasonable in its tone and qualified in its conclusions. They also considered that the correspondence that followed publication added to informed debate on the subject and that this, on balance, was beneficial for the public and the profession."

A major impediment to safety in the NHS at this time was the uncertainty about who bore the responsibility for "monitoring care" in hospitals. Organisations that might have been expected to be concerned included the Royal College of Surgeons who claimed that they only assessed hospitals for the quality of their training. The Department of Health (DoH) accepted "that it is responsible and is accountable for any failings of the systems that were in place during the period covered by the Inquiry."

The Inquiry concluded "The DoH, for historical and structural reasons, was simply unable adequately to respond when an issue of the quality of care was being raised. This is profoundly unsatisfactory."

After Bristol, Monitor only assessed financial stability in Foundation Trusts; the Healthcare Commission (HCC) (2004-2009) and its successor the Care Quality Commission (CQC) (2009-present) were given the responsibility for analysing patient complaints from 2004 but were unable to deal with the volume of work.

Professor Jarman asked the Secretary of State for Health (in 2000) and the DoH (in 1999) for permission to publish HSMRs for hospitals in England. This permission was refused; however the Prime Minister's Health adviser allowed publication by Imperial College and the Dr Foster organisation was set up by Tim Kelsey to publish HSMR annually in national newspapers.

Since 2004 Dr. Foster has provided about half the funding of Dr. Foster Unit at Imperial College and since 2006 has itself been half owned by the DoH.

Results in 2007 showed that two English trusts, Mid Staffordshire NHS Foundation Trust and Basildon and Thurrock NHS Trust, had particularly high HSMRs. On investigation by the then national healthcare regulator (the HCC), Mid Staffordshire was found to have delivered substandard care.

At Mid Staffordshire Foundation Trust, the HSMR showed that were an unexpected number of deaths at the Trust between 2005 and 2009.

A Public Enquiry was set up in 2010 under Robert Francis QC which commenced work in November 2010 and sat for just over a year.

Professor Jarman in giving evidence to the Enquiry said:-

"HSMR cannot give an exact figure for the number of unnecessary, or excess, deaths but one can give a figure for the number by which the actual observed deaths exceeds the expected deaths and give 95% or 99.8% confidence intervals" that this figure is significant.

"It would be impossible statistically to calculate the precise number of deaths that were unnecessary or to pinpoint which particular incidents were avoidable. That would require careful consideration of the case notes

"For each individual mortality the data only indicates, and can only indicate, the number of deaths that occurred (the observed deaths) that are above and beyond that which would be expected of a hospital with a similar case mix, admissions, demographics and other features that a hospital presents. It would then be for the hospital concerned to use the statistics as a catalyst to undertake such a detailed 'case notes' analysis if it deemed this necessary."

The Francis Report condemned the ethos at the Mid- Staffordshire Trust and made 290 recommendations.

Another index developed at Imperial College is used to log changes in quality control over a fixed time. These are the Monthly Hospital Alerts. This information is sent by the Imperial College in a confidential letter to the appropriate NHS Trusts if it "detects a doubling over the preceding 3 months of the odds of death for a number of diagnoses and procedures that cover all inpatient deaths in England". These are calculated from "a series of statistical process control charts" (Cumulative Sum Analysis – CUSUM), of the odds of death for a number of diagnoses and procedures that cover all inpatient deaths in England.

It is of most use in out-of–control systems when for example the death rate rises rapidly in straightforward operations.

The Monthly Mortality Rates were copied to the HCC and now to the CQC; they were first sent out in April 2007.

The recipients of that high Alerts are warned that poor coding, inadequate case-mix as well as poor care may be responsible.

A further important finding was the link between patients' opinions of their care and HSMR. There were highly significant ($p<0.001$) associations between HSMR and questions in the National Survey of NHS Patients every year covering all hospitals. The more dissatisfied responses correspond to higher mortality: it was perceived that hospitals recommended by patients to family and friends were those with low HSMR ratios.

Summary

Administrative data from hospital information systems for all separate patient admissions to hospitals in England have been available since 1987. These are called Hospital Episode Statistics (HES). These data could be used to calculate the HSMRs described above. They can be used as a trigger to alert to a possible problem with the safety of operations and procedures.

The use of HSMRs in the Mid Staffordshire Foundation Trust Inquiry was recounted demonstrating the efficacy of the method. Additionally the association between the dissatisfaction expressed by the patient and her/his relatives correlates well with HSMR values.

Geoff Lewis, Dick Gunstone and Brian Jarman

(Geoff and Dick wrote a draft which Brian edited)

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The great betrayal of the NHS

Allyson Pollock

Allyson Pollock gave this talk to Medicine Unboxed in Cheltenham in November 2013. Information about Medicine Unboxed can be viewed on http://www.medicineunboxed.com/2013-voice/

I trained as a scientist and a doctor, and then in public health sciences. As a public health doctor it is essential to be independent of local management and local politics in order to defend the needs of the local community, just as clinicians must put their patients first. For the last 25 years I have been fortunate enough to work with a group of determined colleagues who have researched, chronicled and protested the steady withdrawal of our health services which began with the privatisation of long term care throughout the 1970s and 1980s and culminated in the abolition of our NHS when the H and SC Act was passed in March 2012.

What greater tragedy than the ending of the sixty four year old duty on our government to secure and provide comprehensive health care throughout England. The NHS is no more. What is the NHS now it has been abolished? The NHS is a 100 billion pound stream of tax funding, a brand name attached to for-profit health care companies and a logo attached to new market oriented institutions called Monitor, (the economic regulator), Care Quality Commission (quality regulator) and the purchasers of NHS care, the Board of NHS England. All three are rushing head long into a dismantlement programme: cutting and closing our NHS hospitals, GP surgeries and community services, mental health services and therapy services; selling them off through contracting out and direct privatisation, eg SERCO and VIRGIN and Group 4; and finally privatising NHS hospitals and services from using foundation trust status. FTrust hospitals are already being franchised out; venture capitalists are investing safe in the knowledge they have been given freedom to generate up to half their income from private patients and private insurance with the taxpayer meeting any shortfall in profits.

Our government's priority is to clear out NHS patients from NHS hospitals in order to cut and close NHS services and privatise the rest and as fast as possible before the election. The so-called acute sector reconfiguration and closure of major accident and emergency departments is just one small illustration. The government is working at break neck speed and it has an army of highly paid helpers in the form of clinical advisors and management consultants. The government is doing this by forcing trusts into deficits in order to both deny people care and persuade people they need to go privately and pay for their care.

Powerful political voices drown out the truth. With their endless drip-feed of press releases they counter the truth using false counter point, remote from reason. The government blames NHS staff and it blames the public and patients. They hope the middle class will exit the NHS soon and lose confidence. Here are some examples of the political voices at work.

First, they attack the NHS staff for bad leadership, and poor management. Leadership and management were superb in Auschwitz; what is new about the leadership over the last two decades in the NHS is that patients interests no longer come first.

Then they blame the doctors and nurses for loss of trust and failure of empathy. This may be true but without an analysis of the new system and how it is exacerbating the problems we can never understand why patient interests were not and are not being served. At the height of the horrible neglect of patients at Mid Staffs the Trust was being prepared for FT status the half way house of privatisation. David Nicholson, former chief executive of the SHA and then the NHS , set the performance targets which resulted in the trust putting finances before patients. The senior NHS leadership was strong when it came to cutting staff and services to unsafe levels and denying care. The leadership was strong in curbing dissent and making staff feel oppressed and fearful and it was strong when it came to ignoring patients and relatives' voices.

Performance targets and measures such as hospital mortality rates are used to create an impression of bad quality and unsafe care in the NHS. They are used to demoralise an already demoralised workforce and to inspire fear in the public. No matter that these data are based on flawed data and statistics generated by companies such as Dr

Fosters, all reliant on tax funding. No matter how much statisticians and public health physicians rail against the misuse of data, performance targets will be dropped but only when they have served their purpose and the government has succeeded in its goal of privatisation.

Finally, having blamed the NHS staff, the politicians blame us the patients and the public. They target groups of patients blaming us for being too old, or for being migrants or for making too many demands on the NHS. They claim that in this age of austerity and, as a result of the aging population and its infinite demands the NHS is unaffordable. This is balderdash. The myth of the demographic time bomb has been repeatedly exploded by scientists and parliamentary committees and reports; so too has the myth of infinite demand for health services. Who among us has an insatiable appetite for health care or infinite need? They ignore the evidence that migrants give more than they take out of the systems. In this Alice through the looking - glass world, the mad-hatter marketeers dismiss science and reason gives way to market ideology. As for not being able to afford the NHS, the politicians forget it was created when we were broke in the aftermath of war: what makes it unsustainable is the high costs of PFI, and economic and market policies. The PFI payments are rebuilding the balance sheets of soon to be privatised banks and generous dividends to shareholders among them RBS and Barclays and Big Pharma and Technology. Just as we gave too much control to the companies that run gas , water and electricity, we have given too much control to pharmaceutical and technology companies whose goal is to persuade doctors and patients to demand products that are not required at extraordinary cost and which use every means available to pollute the science and distort the truth.

But it is not too late to make our voices heard. It is our NHS that has been abolished and that is being dismantled. So, if we don't make our government listen then we will all pay for it.

Hard Truths

The Journey to Putting Patients First or How the Government Plans to Ensure that Patients Appear to Come First when Actually it's (as always) the Quangocrats

David Levy

A first look at the final Government Response to the Mid Staffs Inquiry, November 2013

I trawled this dismal report, mercifully only about 300 pages, as the full impact of my hospital's takeover by Barts is beginning to hit home: hundreds of nurses 'regraded' (downgraded of course) which has already resulted in recruitment blight; a colourful screensaver that reminds us of our innumerable primary duties to CQUIN and QUIP every time we turn our computers on; a Twitter campaign with the forlorn hashtag 'because we care'; and a daily deluge of demands from HQ for unfindable data on 'quality' audits, service improvement questionnaires, and statutory and mandatory training. The CQC recently airlifted in about 80 inspectors across the whole trust for a week's investigation in our 'high-risk' organisation, and it was truly miraculous to witness a beefed-up army of cleaners and maintenance people sterilising the hospital 24 hours a day, a cohort of senior nursing managers who stopped writing protocols for a while, rolled up their sleeves and got down and dirty with the patients, and the Blackberries all a-buzz with code-words for emergency doughnutting of previously unstaffed wards when the inspectors were predicted to march through their newly sparkling doors.

In the light of all this pitiful (and one hopes futile) window-dressing, the government response to Francis, 9 months in the creation, elicits nothing but low moans of despair, right

from the start with a bunch of sentimental platitudes of 'Statement of Common Purpose', including standard mantras of prioritising care for the weakest, compassion, improving lives, everyone counts and the staggering undertaking that 'targets or finance must never again be allowed to come before the quality of care'. Most comical and implausible, 'we will work together to minimise bureaucracy', and just to ensure this, NHS England has introduced a Clinical Bureaucracy Index and Audit of Digital Maturity in Health and Care. Not surprisingly, the response introduces us to a slew of exciting initiatives which will undoubtedly have a galvanic effect on patient outcomes. Try these crackers:

- Informatics Commissioning Group
- Patient Insight Dashboard
- NHS Improving Quality
- Patient Safety Improvement Fellowships
- Patient Safety Collaboratives
- Quality Surveillance Groups (National Quality Board)
- Social Partnership Forum Francis Sub Group
- Federation of Nurse Leaders (The Leadership Academy)
- Malnutrition Taskforce (probably about the 10th in as many years)
- Leadership Quality Framework (The National Skills Academy for Social Care)
- System Leadership Steering Group

It's quite difficult to imagine how even these names were invented. By contrast with this dreary authoritarianism, the report by the American paediatrician Don Berwick (A promise to learn – a commitment to act) published in August, truly does hit home. Its language is elegant and not sclerotic management-speak, and it refused to support David Cameron's demand that we should aim for a zero-risk goal rather than 'continual [risk] reduction'. It must have made him choke on his holiday Prosecco with its largely glowing endorsement of the motivation of NHS staff. Most clinicians will warm to its sentiment, which sounds old-fashioned and old-NHS, and is probably why its 40 pages were published in the dog days of summer, and warrant only token mentions in the government response.

Comments from the Executive Summary of the Berwick Report:

- Patient safety problems exist throughout the NHS as with every other health care system in the world
- NHS staff are not to blame – in the vast majority of cases it is the systems, … environment and constraints they face that lead to patient safety problems
- … the central focus must always be on patients
- Fear is toxic to both safety and improvement
- Abandon blame as a tool and trust the goodwill and good intentions of the staff
- Use quantitative targets with caution.

He recommended that the CQC should be accountable to Parliament rather than the Secretary of State, suggested that regulators should be merged (as did Francis), and strongly hinted that earlier models for public and community involvement (eg Community Health Councils) would be more effective than HealthWatch and Health and Wellbeing Boards. We would all agree that the current NHS regulatory system is bewilderingly complex, and the government response to the reasonable suggestions of both Francis and Berwick increases the likelihood of confusion and obfuscation by multiple authoritarian bodies all clamouring for preference. Clinicians and patients will find it even more difficult to grope their way round this bureaucratic undergrowth, so it's difficult to imagine that real safety – patients feeling they're in secure hands – will improve. By lobbing the subtly-worded Berwick review into the long grass we've thrown away our last chance. Let the bun-fight begin – again.

The Officers Of The Association

At its first meeting on 14th November, the new Executive Committee confirmed Officers for the next 12 months to be.

Their contact details are as on the Executive Committee list in this Newsletter.

Co Chairs
Dr Jacky Davis and Dr Clive Peedell

Hon Secretary
Dr Malila Noone

Hon Treasurer
Dr Jonathan Dare

Peter Fisher
President

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