NHSCA

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Think of the consequences

This July, a passenger aircraft was shot down over Ukraine by a ground–to–air missile which, it seems likely, was provided to one of the armed groups in the area by a third party. This appalling event raises many issues, including the immorality of the arms trade and the results of interference in a neighbouring country's territory and politics, and beyond this there are the issues of unforeseen consequences. Those operating this complex modern equipment almost certainly had no intention of annihilating 298 innocent travellers, neither, presumably, did the providers think they might. It seems likely that inadequate training, against a background of inexperience of such dangerous equipment, resulted in this disaster. Unforeseen, but not unforeseeable.

Nearer to home, we are increasingly aware of decisions about clinical services made by those who know little about them, do not wish to look at the evidence and ignore all expert advice on the grounds of vested interests. Have they thought through the consequences? The Coalition seems to be rushing headlong and deliberately towards a US-style insurance model, but have they really considered all aspects of what it will mean if this is the outcome?

Across England, most CCGs have adopted the frequently promoted mantra of 'Care Closer to Home'. It may seem like a good idea initially and may win a few votes. 70% of contracts for clinical services have now gone to the private sector but such clinics are usually staffed by GPs with a Special Interest (GPSIs), many of whom do not fulfil the supposedly mandatory experience and training criteria for such posts. David Eedy points out that the use of these 'community' clinics has never been shown to reduce hospital waiting lists, they threaten to destabilise the hospital service and they cost a lot more than hospital clinics. The service thus provided is not acting as a useful filter to reduce hospital referrals and causes only delay in reaching a true specialist service. Further, we cannot ignore the inevitable impact of this continued outsourcing on education of students and trainees as the service is fragmented. At a recent public meeting a woman who had attended a local private sector dermatology clinic told us that she could not fault the service - everyone was very professional and the surroundings pleasant - except that they could not deal with her problem and she had to be referred on to the hospital. Not a good use of public money and all this was eminently predictable.

Outsourcing usually does result in patients being seen by less well trained and less experienced staff as well as much performance management. A local private-sector talking therapies service which has taken over NHS staff expects them to be present at work but does not pay them if the patient fails to attend –(is this a zero hours contract?) - while some outsourced community carers have been forced to make shorter visits to patients' homes and

are no longer paid for travelling time.

In the Netherlands similar pressures on district nursing and home care had been occurring, with great reductions in trained staff. In the last few years, an interesting 'Buurtzog' initiative in community nursing, mentioned by Roy Lilley in his 'NHS managers net' blog, has shown that use of relatively well paid and experienced nurses with a high degree of autonomy has resulted in more effective care with patients needing fewer visits. An additional bonus has been a reduction in sick leave and a much lower turnover of nurses, a predictable outcome as a degree of autonomy has long been shown to increase job satisfaction.

Nationally, in the English NHS the Health and Social Care Act, combined with austerity and a massive squeeze on NHS budgets, is having a very serious impact. Linda de Cossart and Della Fish mention concerns over the morale of young doctors and their enjoyment of their professional work; in an MPS survey last year 1/3 were apparently reconsidering their career choice. Constant media scare stories (eg, in the Mirror: 'GPs failing THOUSANDS of cancer patients by failing to spot early warning signs'), combined with ever-increasing workloads, are demoralising and frustrating for the senior staff who should be their mentors and role models. The 'Sun' recently urged its (literally) misguided readers to phone in with their NHS horror stories, so more will doubtless follow. Management manuals suggest that constant reorganisations, an environment of uncertainty, stressful competition between people and departments and a feeling of being unappreciated are very common reasons that people are unhappy in their work and wish to leave. Does this sound rather familiar?

Understaffed A&E units are unable to appoint new consultants as so many have emigrated in search of a better working environment. There appears to be a crisis of GP recruitment too, both to practices and to out of hours services, where we are told that 60% of providers have gaps in their rotas. Privately run GP services can be, and have been, abruptly terminated, presumably because they are insufficiently profitable. Could all this have been predicted? Of course it could. GP funding is in crisis, hospital funding is ever more precarious because of reductions of tariffs and a constant 'cost improvement programme', while the Health Service Journal describes chaos in specialised commissioning. Bringing down flight MH17 cost 298 innocent lives and was probably a dreadful mistake, but these NHS policies, if continued, will cost a great many more lives than that and result in far more suffering, physically and financially, in years to come. This can be predicted by looking across the Atlantic where the US system is the least cost-effective and most expensive in the world, where at least 26,000 Americans – up to 48,000 in some estimates - die each year from lack of medical care and where health costs are the commonest cause of bankruptcy.

Is there hope of a change? A recent Yougov poll shows massive support for public funding and provision of public services, particularly the NHS (84%) but also others such as railways, water and electricity. A ComRes poll in July 2014 showed that, although tax rises are generally unpopular, 57% would support a tax increase to maintain current care and services in the NHS. Probably even more would do so if the predictably wasteful market could be dropped. Can we follow Scotland and Wales and go back to public provision? Andy Burnham has made some encouraging statements about his proposals if Labour wins the next election, but Ed Miliband's intentions are not altogether clear. Or will we (I write this as Liverpool has again hosted a 'Giant Spectacular' street performance with huge and wonderfully expressive puppet figures) see even more of the NHS taken over by Virgin, Serco and other international 'giants'?

For most of us, failure to recognise foreseeable consequences, or foreseeing them but ignoring them, constitutes negligence, about which the GMC has views.

Public awareness is slowly rising, though relatively few people seem to realise the enormity of the damage being caused to the NHS or the ultimate aims of the policies. Can the new Jarrow march, soon to set off as I write, possibly be the trigger to alert the public to the dangers, and induce our politicians to look at the evidence, not the ideology?

ANDREA FRANKS
Guest Editor

Dermatology in Crisis: the new NHS

Dermatology today faces a number of challenges, some of which will be familiar to many other disease specialties, while others are largely unique to dermatology. With Simon Stevens, the new CEO of NHS England stating that three quarters of the NHS should be handed to private companies in the next decade to encourage "disruptive innovation", the problems may well get worse.[1]

A major issue is the lack of political will. The government still does not see skin disease as a priority area. Whilst dermatologists are doing what they can to highlight their patients' needs, for example by influencing the commissioning process, it requires other stakeholders to recognise the risks to patients and services and to militate for changes that will alleviate the burden of skin disease in the UK.

What are the fundamentals? Demand for dermatology services is at an all-time high, with more than half the population every year suffering from a skin condition. An ageing population and an exploding incidence of skin cancer (now the UK's commonest cancer[2]), is putting huge strain on a specialty with around one fifth of its 800 consultant dermatologist positions unfilled.[3] Sadly, non-specialist manpower for patients with skin disease is presently inadequate. Teaching in medical schools ranges from sub-optimal to non-existent, and GP training in dermatology is optional and inconsistent. Radical, unpiloted and unmonitored changes in healthcare threaten services that have evolved and developed over decades, and they fail to ensure equitable access to the present limited resources.

Demographics and demand

Politicians, hospital managers and even medical colleagues often have little understanding of the needs of patients with skin disease and the work of dermatologists. This is in part an inevitable consequence of the sheer breadth of the specialty, with over 2,000 skin diseases diagnosed and treated by the specialty.

More than half the UK population experience a skin condition every year; and 23–33% at any one time have a skin disease that would benefit from medical care. Skin disease affects all ages. There are rashes and eruptions due to eczema and psoriasis, to acne and urticaria and, increasingly, to drugs used for other diseases. Many skin diseases are long-term and chronic, with a huge associated psychological morbidity; and people's cosmetic expectations are increasing. For many patients skin disease is life shattering with severe cosmetic and psychological consequences. Skin disorders are more than just an annoyance. Skin cancer is now the UK's commonest cancer, and its incidence is rising with no sign of slowing down[2]. Chronic sun damage and multiple skin cancers make this the most significant dermatological long-term condition. Skin disorders, including skin cancer, also arise in patients with other medical problems (e.g. HIV, diabetes, organ transplantation, immunosuppression) and from the side effects of drugs for other diseases.

Yet despite the pervasiveness of these diseases and the huge impact they have physically, cosmetically, emotionally and financially on people's lives, dermatology has suffered from the negative impact of non-evidence-based health service reforms, with patients consequently suffering. There are few true alternative providers for skin disease patients, because dermatological teaching in medical schools is sub-optimal and specialist numbers insufficient, and changes to healthcare provisions threaten existing vital services. Patients are too often seen in community settings, and treated inadequately by several different providers before eventually being referred on appropriately to a consultant-led dermatology department, which is usually struggling to cope because of depleted services. These patient pathways are financially ineffective, and the limited resources available would be better directed towards consultant-led services. Urgent recognition of these problems is essential; and prompt remedial action needs to be taken before life-saving and life-enhancing services become irreparably damaged.

The workforce

The increased demand for dermatology is not matched by the small number of trainees allowed into the specialty, with around 180 unfilled consultant dermatologist positions out of 830 posts available. About 25% of these funded but empty posts are "taken" by unaccredited locum consultants[3]. Depleted hospital services struggle to cope, and there is pressure from Shape of Training recommendations[4] and the RCP's Future Hospital Commission[5] project to divert doctors, especially those in training, towards acute medical services. All of this is exacerbated by the fact that dermatology training for undergraduates and postgraduate GP trainees is non-mandatory, and usually for less than a week. The Chief Medical officer of England, Dame Sally Davies, after meeting a group of dermatologists concluded in a letter to Ian Cumming, CEO HEE as "I was left horrified by how this is a profession in

real crisis[3]." She went on to say that "if we wanted to get dermatology right, then the UK would need 6000 consultants (roughly equivalent pro rata to Germany, France or Italy) rather than the 684 (471 WTE) and 197 funded substantive vacancies, of which 104 are filled by locums, at least half of whom are long term (>6/12) and two thirds of whom do not have CCT or CESR in the specialty"[3].

Only 20% of GP vocational training schemes contain any dermatological component. Newly appointed GPs therefore have little experience of dermatological problems. This is woefully inadequate, particularly considering that there are over 2,000 skin diseases, and that skin conditions are the commonest problems seen in primary care. There appears to be an "inverse training law" in operation in dermatology.

The is a huge north / south divide with the South East Coast, North East and East Midlands being in largest deficit, but most areas outside London being badly hit. Older consultants feel under siege from the changes to their profession, while younger, mostly females, are more likely to be part time, take time out of service or geographically tied to central London. The Care Closer to Home mantra simply has not delivered: where implemented it gave rise to a 67% rise in referrals to secondary care[6]. Massive increases in the rates of skin cancer, changing expectations of patients and unrealistic targets have sent many dermatology departments into vicious spiral downwards. False beliefs and tensions between general physicians and specialists in the Shape of Training and Future Hospital Commission have added to frustrations in the specialty.

Doctors in other medical areas have had little exposure to dermatology in medical school, and likewise for nurses. Another unreported crisis is the loss of specialist dermatology nurses, presumably due to increased "care" in the community, and privatisation.

The UK healthcare service requires dermatological patients to be seen by the right people, in the right numbers, in the right places, with the right skills, to give them the treatment they need and deserve.

Delivery of specialist care

Over 90% of dermatological work is in outpatients, and up to 50% of that may now be surgical because of the skin cancer epidemic. There has been pressure to move much of that work into the community, resulting in consultants doing clinics in several places dispersed far away from their previous single-site hospitals.

However, there is still a need for inpatient care for the sickest patients. In many hospitals, inpatient dermatological care has moved deleteriously from dedicated wards towards beds dispersed throughout the hospital. Dermatology patients require specific facilities within dedicated wards, including bathing and treatment rooms, with access to specialist nurses to apply treatments. The standard of care in general wards cannot match that available in specialised wards. Furthermore, increasing numbers of inpatients admitted under other disciplines, such as orthopaedics or infectious diseases, also suffer skin complications. Reasons include an ageing population, co-morbidities, polypharmacy, and new drugs with dermatological side-effects (especially in cancer treatment). This has naturally led to more in-patient consultations by dermatologists on other wards. It is estimated that five dermatology consultations are required per day per 1,000 beds.

Ward rounds have ceased and are not recognised in job plans, with a negative impact on both patient care and education, as registrars, specialist nurses and students are denied training, and inpatients are less likely to be reviewed by experienced specialists.

By dispersing dermatology patients throughout general wards and moving clinics away from hospital sites, resources have been spread thinner, with expert teams of doctors and nurses no longer always available in the right place, at the right time.

Care in the community

Dermatology has suffered disproportionately as a specialty, being seen as easy for commissioners to shift into the community, due to the widely held but mistaken view that skin diseases are minor simple ailments that can be easily identified and treated locally.

However, the drive to shift treatment into the community, and the decommissioning of dermatology outpatient services, has not achieved its aim of improving patient care. Instead, there are increased referrals to both community and hospital services.

In most cases the cost of care remains the same—perhaps even more per head—for the community as for the hospital service, not including the additional patient care costs for those lost on the referral pathway between their GP and the community before they ever reach secondary care. A study by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) concluded that the policy of opening GPwSI clinics for patients

with uncomplicated problems in primary care, to reduce hospital waiting lists for those with more serious conditions, had failed[7]. The cost of these facilities is far greater than equivalent hospital clinics, and they have no positive impact on hospital waiting times. The importance of patients having access to a high standard of cost-effective care and expertise overrides the convenience of having this service in the community.

Alternative providers and egregious commissioning

To maintain high standards, a large degree of public accountability must be maintained, from the beginning of the tendering process through to the treatment of patients and beyond. However, commercial confidentiality clauses, not applicable to the public sector, can stifle transparency when private companies are involved in bidding for healthcare provision. This makes it hard for external bodies to scrutinise whether the new service is compliant with national guidelines. There are also very real concerns regarding "cherry-picking" by private providers: that the private sector is more likely to take on relatively easy, high-volume, lucrative work in the interests of profit. The local NHS hospital department is then left to pick up the more difficult and expensive work under increased financial pressures. There have been cases of independent providers tendering for dermatology services without having accredited dermatologists or suitably trained staff. They are either unaware of the current shortfall in dermatologists, or assume they will be able to employ dermatologists from local services after gaining the contract. The BAD published (in 2013) a much-lauded and oft-consulted document on "Lessons for the NHS from Dermatology"[8] about the pitfalls for patients and services of egregious commissioning.

Although there seems to be very little desire amongst dermatologists to work outside the NHS, there is a risk that private providers will drain already-stretched resources. Not only might this lead to even fewer dermatology consultants in the UK, but it also diverts money that would otherwise be available for training and research within the NHS to private providers, with no incentive to provide equivalent structures. There are also worries about the quality of staff employed by some providers. A Certificate of Completion of Training (CCTs) confirm that a doctor has completed an approved training programme and is eligible for entry onto the GP or the Specialist Register; but doctors without CCTs are being legally appointed as locum consultants, leading to many dermatological posts being held long-term by someone without a CCT. Worryingly, unaccredited locums, possibly based elsewhere in the UK or even abroad, are providing "governance" for GPwSIs. Although compliance directions for GPwSI accreditation and services were set statutorily in June 2007, enforcement and guidance is patchy. It is challenging for medical professionals, let alone the public, to ascertain the degree of training and the level of accreditation and supervision of a GPwSI service.

For the diagnostic and therapeutic needs of Britain's skin patients, there is no realistic alternative provider to the specialist consultant dermatologist. We are trained, accredited, experienced and vocational professionals. Working with patients, colleagues in primary care, other specialties, commissioners and management, we want to consistently do better for our patients. We feel frustrated, marginalised and disillusioned by what we see unfolding.

Our services have been built up over many years, and it is tragic to see this disintegrating at a time when patients need dermatology services more than ever.

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(The views expressed in this article are the personal views of the author, and do not necessary reflect the views of the British Association of Dermatologists.)

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Rescuing Out Of Hours Care

Ever since I first walked the wards as a medical student in 1965 there have been prophets of doom for the NHS, generally senior staff with some personal grievance. Despite this the NHS, like the Queen, remains a national treasure in surveys. So do British-trained doctors, unlike those in the USA, who are seen as defensive and venal.

The NHS began in 1948 in post-war austerity with an ethos of dedication to achievement of more effective and equitable health care. There was also an underlying philosophy derived from military service that patients were basically worthy, able to be patched up to return to service,and definitely under 65 unless dealt with by specialist geriatricians. About 2.5% GDP was devoted to health care, a figure optimistically expected to fall as people got fitter. The service had to be accommodated in heterogeneous elderly premises, but there were plans to build new district general hospitals everywhere to replace Victoriana and Emergency Medical Service war-time sheds. My own disease palace sported a model of the 1949 rebuilding plan: a partial rebuild did occur in 1973, and a completely new clinical building opened in 2002 under PFI ("there is no alternative"). Ironically times have changed and what would have been very useful in the 1950's is not fully utilised, with few in-patients. Poignantly, the rather solid residual Workhouse has been refurbished as offices and teaching accommodation.

There was intense medical opposition to the reform plans of the 1945 Labour government, and it was only Aneurin Bevan's persistence and financial incentives that persuaded senior hospital doctors to join in. General practitioners insisted on being independent contractors. However, there was a general agreement that out of hours care would be organised 24/7 by GPs, and hospitals would accept emergencies on the same basis. The NHS was unexpectedly popular (a trend which continues to increase!) so that charges were introduced for prescriptions, dental treatment & false teeth, and glasses, though always more modest than elsewhere.

Current problems for the English NHS include a dramatic increase in life expectancy with greater medical needs, reductions in acute medical beds (not seen to nearly the same extent in Scotland, which values more highly small hospitals), swingeing reductions in mental health beds, and not least the withdrawal of GPs from overnight and weekend care. This last followed botched contract negotiations in 2004; the offer of £6,000 additional to continue out of hours care on top of a basic income in six figures was an irresistible incentive to let someone else organise this bit of the service.

An inevitable consequence was loss of important professional interest and challenges for GPs, and often severe difficulties for patients struggling with what seems a perversely unhelpful OOH system.

The 48/56 hour week was the right way to go - nobody functioned brilliantly on the 83/104 hour weeks we regularly operated - and the much greater intake of women is to be applauded, though it must be accepted that necessarily female lifestyles mean a likely commitment of 2/3 wte compared with men. However, as the government says, there are a lot more doctors and nurses employed in the NHS now, so it is hard to believe they are doing the right things! My year enrolled in 1963 in Birmingham was around 120 matriculates; in 2014 there are 327 places, plus new undergraduate clinical schools have opened at Leicester, Nottingham and Cambridge, all in the former patch. Despite this increase in British graduates and abundant supply of local applicants for training 1/3 of our hospital doctors are foreign graduates, often coming from worse medically-provided countries. Ostensibly this is for training, but often results in employment in service posts without significant educational value.

The present criticisms of the NHS often focus on the perceived difficulty of obtaining prompt qualified help for medical problems, especially by Primary care doctors outside usual office hours. This leads to inappropriate use of ambulances and Accident & Emergency departments, inevitably causing queues and delays. This is frustrating for staff and patients, and may itself generate avoidable dangers.

How can we retrieve the situation?

Tactical and strategic moves could usefully include;

1. Stop closing small local hospitals; value them for providing accessible basic services for the elderly, children, longterm cancer care, and the mentally ill, vulnerable groups who themselves and their relatives benefit from not having to travel long distances.

2. Renegotiate the GP contract to make the job more professionally rewarding. Care needs to be personal rather than mechanical implementation of official guidelines, which may prove counterproductive as the current controversy over the potential overuse of statins shows.

3. Accept that generally all NHS doctors have some responsibility for out of hours care. This would be a big change for GPs, but could be made acceptable by financial adjustments. Reassuming continuous 24/7 responsibility for patients might account for 1/3 of an increased income. Many GPs may prefer the option of a salaried contract on this basis. Exact arrangements for delivery of a comprehensive service could include late evening surgeries, and overnight and weekend on-call duties on a rotational basis , followed by generous time off to compensate. For collaborating group practices this might only involve unsocial hours every fortnight or so.

4. Require all trainee doctors work for a spell of at least 3-4months in A&E as part of basic education.

5. Rediscover the concept of General Physician / Surgeon/Paediatrician/ Orthopaedist with a special interest, accepting responsibility either personally or through juniors as appropriate for out of hours care.

6. Make the posts of Accident and Emergency consultants time-limited with a proper subsequent career structure; these intensely high-pressure jobs must otherwise lead to disillusion and burn-out.

7. Reach the happy point where all UK service posts are matched by an equal number of UK-trained doctors, and non-EU graduates really are here for training purposes unless they are refugees.

8. Require that those UK citizens undergoing British medical undergraduate training, inevitably subsidised by the tax-payer to a large extent, should work a minimum time for the NHS or repay the true cost of their privileged education.

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Centre for Health and the Public Interest: An Appeal

The appeal for support for the CHPI in the last issue of the Newsletter unfortunately omitted a link to an account of the first year of the Centre's work, and the names of the eminent clinicians and others who have given us their support.

A corrected version of the appeal is now available separately on the NHSCA website, but the key document is CHPI's One Year On, which you can see at http://chpi.org.uk/wp-content/uploads/2014/05/CHPI-1-Year-on-Apr14.pdf. It shows who is behind the Centre, what we have done so far and what impact it has had.

In spite of this glitch, several NHSCA members have generously come forward with donations, for which we are extremely grateful. If you were wondering about us in June please take a look at One Year On now and consider joining them in supporting our work.

Professor Marianna Fotaki, Professor Colin Leys and Dr Sally Ruane, for the CHPI Executive Management Team.

Education matters:
the challenge for consultants, their profession and their employing organisations.

(We declare that the arguments we offer here are our own and should not be attributed to any organisation to which we are affiliated.)

Introduction

As a consultant what do you believe is the purpose of postgraduate medical education? Do you think it is working and achieving what it should?

We would argue that the purpose of PGME is to produce a wise doctor (see figure I) who aspires to be an excellent practitioner, who cares about patients and who is mindful of their responsibilities to account for their professional decisions and actions, and who loves their job. However, the utilitarian environment and the technical processes to which young doctors are exposed in current clinical practice seem to us to be very significantly affecting how they see themselves, their professional education and their everyday practice. All too often the pride in being a doctor and their happiness in their chosen career with which they begin their first post, quickly becomes dented and significant stress and disillusionment build up as they lose sight of their aspirations in the challenge of progress and survival.

Particularly worryingly is the mindset induced by the narrow technical focus of their environment, which insidiously fosters a dehumanising approach to patients and a narrow and self-serving competitiveness in being a doctor (BMJ 2014;g2651 doi: 10.1136/bmj.g2651 (published 9 April 2014). The evidence for this in the very language which gives away the system's attitude. For example patients are now often referred to as 'breachers', doctors 'deliver care' in 'packages' and work 'on the shop floor'. Worse, the target-driven agenda leave no time for those subtle signals of human contact, caring and compassion that Kate Grainger (herself a doctor) so eloquently notes are important (http://www.dailymail.co.uk/health/article-2651096/How-NHS-dehumanises-patients-doctor-32-dying-rare-form-cancer.html). The safety of patients (and we would argue, the future of our healthcare system which in the future will be in the hands of our young doctors) is at risk if this continues to proceed unchallenged. Better postgraduate education is needed not quick fix training events.

We recognise that attempts have been made over many years, to professionalise PGME and in the last decade there have been the greatest ever technical and structural systems put in place. These have to date created (unintentionally) a series of assessment hurdles which junior doctors need to negotiate to justify their professional progression and status. All claim to be in the name of 'patient safety'. We do not dispute that these are necessary but without underpinning these systems by what would be classified as sound educational processes based on quality education (postgraduate teaching, learning and assessment) they will never achieve their desired aims. Indeed, this failure is already palpable at the heart of practice itself where the mind of 'trainees' is almost exclusively focused on keeping safe medically and having a CV that will get them the next job. Enjoying being a good doctor and aspiring to become an even better one is lost in this frenzy.

Our view is that the safety of patients and the well-being of the future guardians of our profession depends now upon the following three urgent matters. The ***first*** is that PGME needs to align itself more centrally to the principles and processes of sound quality education (teaching/supervision) in the clinical setting rather than the narrow and instructional processes of simple training. ***Secondly***, organisations within which doctors who require supervision work (in acute healthcare settings this means two thirds of the medical work force) need to recognise the central nature of the education of practicing doctors as crucial to safe patient care, and need to be far more supportive of it in everyday clinical practice. ***Thirdly***, the responsibility for improving this state of affairs lies, in our view, with the consultant body who need to take leadership to change hearts, minds and actions in respect of making more time for better postgraduate medical education.

What follows therefore are some key points about what we mean by quality education including the principles and processes that make for quality teaching together with the gist of the arguments that consultants need to make to key personnel in organisational bodies about these matters. The key educational points are that PGME far from being seen as 'a mere waste of time' must be recognised, respected and provided for as a major element in the core business of all healthcare providers and because it is ultimately at the heart of continuing safe and quality patient care.

Principles and Practises of quality education in PGME today and the future

Clinicians and teachers urgently need to reconceive the purely technical mode of PGME (important as it is) as seated in a wider educational practice. This needs to attend to developing the character the doctor brings to their medical practice and strengthen the human elements of that practice thus allowing them to progress to becoming a more expert doctor. The purpose of this being to create professionals who are able to support, advise and care for people at their most vulnerable moments in a way that is specific to doctors and different from what other healthcare professionals can do. In order to attend to this, we need to develop supervisors as teachers who understand what it is to work in the moral mode of practice as summarised for doctors by Fish, 2012 (1). Central to this is good teachers making more out of real clinical cases by rigorous and meaningful reflection on decisions and judgements made by their supervisees during those real clinical encounters.

This must lead to respect for medical teachers, time for sound teaching and reward and status for those who strive to make the care of patients safer through better clinical supervision and teaching. Developing the supervisors as better teachers is essential and the wise adage of Lawrence Stenhouse that there can be no curriculum development without teacher development is central to this (2). Such efforts we believe would also have effective and efficiency gains for both organisations and individuals.

Arguments for supporting PGME in the clinical system

Personal exploration by the authors has revealed that most managers in healthcare have little knowledge of the benefits that doctors in training bring to their organisation. More seriously they have very little understanding of what doctors in training do, think or aspire to. Their ignorance is reminiscent of the comment in Monty Python's "Life of Brian' (1979) 'What have the Romans done for us?'(3). A parallel might be a manager in healthcare without doctors in training, in years to come might saying:

> *All right... all right... but apart from providing two thirds of the medical workforce to run our organisation; bringing in many millions of pounds; motivating consultants; undertaking important audits and research; bringing new ideas to the organization; being champions of our ways of working; being the seed corn for future employees, what have Doctors in Training done for us?*

Senior clinicians must help managers, to understand better that the education supervisees receive is not only part of our social responsibility paid for by society, it is crucial to the complex expertise in patient care they need to develop. Knowing these facts and communicating them to managers is an extremely important responsibility for consultants.

Educational Leadership Roles in PGME for senior clinicians

We have written previously about how we see the capability and expertise of educational leaders in PGME as intellectual, moral and practical (4). Their key role is, through the practice of education, to engage in teaching in the clinical setting to nurture and support the emancipation of young doctors through paying the learner moral and intellectual attention (which means knowing each learner and attending appropriately to their crucially differing wants and needs) (5) and to enrich juniors' medical and human understanding, expand their insights and deepen their thoughts and feelings, all of which are so influential in their clinical decisions and professional judgements (6,7,8).

Nothing motivates professionals more than doing the job they want to do with pride and a sense of development and progression. Clinical teachers and supervisors must be given the space to support doctors in training to do just this by understanding what is involved in clinical teaching, improving managers' understanding of

the importance of this and becoming champions to make this happen now.

Figure I: Being a wise doctor is about:

- understanding the values that drive your practice **as distinct from just doing a job**,
- understanding the importance of context **because everything is context specific**,
- being able to articulate the thinking that underpins your decision making **not just following protocols**,
- being able to make your own wise professional judgements **not just doing what the boss wants!**
- being able to create a therapeutic relationship with a patient and **going beyond safe patient care to caring about the patient**,
- having self knowledge **not just being skilled**.

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The Crisis in NHS General Practice

If you speak to doctors through the years they will always say how bad things are or they have never known it so busy or tell you about the latest crisis in the NHS. It's a bit like farmers always saying how bad things are.

So true to form I will tell you how bad it is now... as a GP for 15 years I have to say that I have never known it so bad and I will try and tell you why.

We have the toxic combination of an English NHS under political and media attack like never before and general practice on its knees with huge increases in workload and a workload disaster looming with GPs retiring early and junior doctors shunning general practice as a career option.

Since 2010 many of us have been campaigning against the political disaster that is the English Health and Social Care Act. This is an England only piece of legislation that has laid the English NHS wide open to the private sector. The huge upheaval of creating Clinical Commissioning Groups (CCGs) has meant vast amounts of time have been spent on administration and CCGs leaders have had their attention diverted away. Countless millions of pounds have been wasted on redundancy payments and then rehiring the same people who were made redundant. You couldn't make it up could you? CCGs now have to put contracts out to tender for fear of falling foul of the Health Act (specifically the section 75 aspect of the Act).

It is estimated at least £10bn has been wasted on the market in the English NHS up to now with the cost of legal fees, accountancy fees, management consultants and the huge amount of time needed to put contracts out to tender. Imagine if that £10bn had been used on patient care.

Nearly every day we see press headlines of how bad the NHS is and how staff in it don't care, don't do their job properly, leave patients dying in pain or just neglect their work and are highly paid fat cats. Yet all I see around me is highly dedicated doctors, nurses and others working their socks off to provide high quality care for their patient's day in day out and going the extra mile to do so. GPs now often work 13 hour days and see over 60 patients a day and deal with huge amounts of admin and bureaucracy – yet you never hear a politician acknowledging this do you?

Funding for general practice has fallen year on year despite what you read in the Daily Mail. We now have the lowest share of the NHS pot ever and yet we see over 1 million patients every 36 hours. We are constantly chasing targets and having to dance to the tune of CQC, NHS England, CCGs, Local Area Teams, Department of Health – all of whom have their own whizzo ideas of how to make general practice better when they haven't got the slightest clue about what it is like on the shop floor. Their rose tinted spectacles become more and more tinted as the years go by.

All of this has led to GPs just throwing the towel in. Those in their mid 50s who would have worked for another 5 years have just had enough of the constant battering they get. They are leaving in droves. Funding for practices is often inadequate to make them run properly so we are also now seeing GPs hand the keys back and close the surgery down – something you would never have believed happening 5 years ago.

As a consequence trainees see all this happening and don't want to touch general practice with a bargepole. Many are choosing to go abroad to Australia or New Zealand who welcome them with open arms, good pay and decent working conditions to boot. Those who do stay in the NHS choose to train in hospital specialties. The number of doctors training to be GPs is at the lowest level ever and huge numbers of training places are left unfilled. It is a frightening scenario for those of us left in general practice mid career.

So who is to blame for all this – well it's the politicians and media of course. The Tory and Lib Dem coalition voted for the English Health Bill which has fragmented the NHS ready for the private sector to move in and buy it – and the private sector are doing so hidden behind the well trusted NHS logo that is world respected and the envy of the world. We should remember the NHS was once more declared by the independent

Commonwealth Fund to be the best health care system in the world.

Many politicians have business interests in companies who win contracts in the NHS and this is well documented on the internet – just type 'politicians business interest in the NHS' into a search engine.

Our medico-political leaders have the ability to make big noises day in day out about the threats to the NHS and they must do so much more if we are to save it. The likes of the Kings Fund and NHS Confederation were quite happy to go along with the Health Bill and many of their senior employees/trustees have track records of being quite happy to see a commercialised NHS come about.

Politicians and the media have presided over a 'trash the NHS' agenda over recent years – many think in order to do down the service and allow others to say 'look how bad things are, we need to bring in the private sector'. This is exactly what happened to the rail industry running up to its rushed privatisation in the dying days of the Major government in 1996. And look how the private companies have profited from rail privatisation!

All in all it is a very dangerous time for the English NHS. It has never been under threat like this in its 66 year history. 'What can we do' I hear you ask? It is a good idea to buy the book 'NHS SOS' authored by your co-chair Dr Jacky Davis and myself. All profits go to the non partisan Keep Our NHS Public. It details in the final chapter what you can do to save the NHS.

It is vital we pressurise politicians and the more that do this the better. Send a brief letter via www.theyworkforyou.com and say you don't want the NHS to be commercialised in England and contracts sold off to the private sector.

We must all work together. We are all busy and we are all under huge pressure – but we must show leadership as doctors and defend the NHS for our patients – because once it is gone there will be no going back.

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The Attacks on the NHS

Following well publicised shortcomings at hospitals reviewed by Keogh ,Jeremy Hunt took the opportunity to blame the NHS but the detailed reports do not reveal a fundamental flaw but show a system under stress and Keogh often commented on the dedication of staff within the service. The sensible action is to support and encourage such dedication through a reaffirmation of the strengths and values of the NHS and now to restore it as a comprehensive service to move forward through co-operation and to end destructive competition.

Other attacks are more insidious through the repetition of half truths, selective data and creeping market based vocabulary.

The Threats of Commoditisation of Health Care, Privatisation and Marketisation

(i.e. making a commodity – saleable item of something not previously considered saleable)
At the risk of arguing over semantics these threats have differences which will be used by politicians to deny that they are undermining the NHS.

Everyone understands public and private ownership and most understand the implications – publicly owned means members of parliament or local councils are responsible, accountable and removable through elections. Private means none of the above, services may be subject to contracts which can become problem areas themselves as described in Perils of Competitive Tendering – Part 2, in the June issue.

With a publicly owned & provided NHS we have control over how we provide care; health care is an entitlement, something everyone, by right has access

to. It is the state's duty to provide the best they can, naturally this will be limited by the resources available and rationing must be seen to be based on equity. As employees of the NHS we have known a real sense of ownership in the widest sense – that the NHS not only belongs to us but is something we have made together for everyone in the country with a true sense of pride in our achievement and desire to nurture the service and to provide continuous improvement.

In my hospital, in the early nineties in one of the first Trusts (and later one of the first Foundation Trusts) we had much input from management experts and consultants who brought with them their marketing philosophy and spent much time asking us to consider our core purpose and branding. This time was wasted as research amongst the public has shown the most trusted brand to be the NHS itself and its purpose is self evident.

Trusts and later Foundation trusts were intended to benefit from more financial independence which led to many competing for the easy to manage work that brings in the money – elective surgery and most trusts competed for the same patients requiring one off procedures. Subsequent events showed some trusts to prioritise income generation through competition for elective services to the extent that they underprovided emergencies for their local population as described in the Francis and Keogh reports. One Councillor described his local Trust as pulling up the drawbridge on becoming a Foundation Trust (FT). The Keogh report identified isolation either geographical or philosophical as a factor in hospitals that allowed their standards to fall.

Where this happened the remedy is obvious - to restore links with the local community and to develop a constructive dialogue to improve health in the locality. This is where the NHS can score highest, but even before the fragmentation began the service needed to be more democratic. The old NHS had Community Health Councils that really were patients' advocates and we do need a stronger patients' voice – discussed in a separate column.

The changing patterns of healthcare and the changing conceptions

Healthcare is often seen as a series of interventions, which is how most economists would see it and this approach suits some conditions, particularly those which are curable (estimated at 10% of activity) For many patients illness is a long term experience – many speak of a journey and interventions may happen along the way affecting their state of health but the illness is owned by the patient.

When we become ill we want effective treatment and expect it to be delivered in a co-ordinated manner and hope to be cured but accept that there are limits to what can be done, we expect equity in provision (not a post code lottery). With the old NHS that was not a great problem patients were given what the service could provide with clinicians being continuously aware of the need to use limited resources wisely. Patients with long term conditions knew the service from GP to specialist would respond according to their need.

The NHS, like health provision in other countries costs more each year for many reasons and it is in everyone's interest to ensure value for money – we can look at each item of work that we do and give it a value. We can look at treatments and assess their value through a system of Quality Adjusted Life Years (QALYs). This is very crude but it is the best economists have done in respect of providing a rational basis for resource allocation and too often looks at cost rather than value as in the example quoted from Harry Keen that you can easily work out the cost of an operation when a surgeon amputates a diabetic patient's leg if gangrene develops but can we identify the cost and value of the physician's work in controlling diabetes and preventing complications?

This may seem a moot point and that it is in the patient's interest to be kept in good health but it illustrates the situation in evaluating hospitals at the time of the introduction of the internal market in the early 90s. Hospitals were judged on their activity which, in turn was measured by procedures so that a hospital doing more operations was considered to be more effective than one which through better medical care, required fewer operations to be done.

We have moved on but the funding of healthcare is still based on the input from providers and not the benefits patients receive – the inherent problem of the internal market. Otherwise known as the purchaser provider split with groups of professionals separated and competing rather than working together.

One of the great strengths of the NHS has been coordinated planning which meant that services were provided where they were needed – a network of hospitals with a DGH or teaching hospital within reach by ambulance in emergency to serve the local population. Provision of GP services has been more equitable since the foundation of the NHS. Pre NHS there were fewer GPs in disadvantaged areas and there was overprovision in affluent ones. I am told that there were ten times more GPs per capita in Hampstead than Hartlepool.

Whilst most GPs remain independent contractors, the establishment of GPs in poorer and more needy areas has brought more equity illustrates a basic principle of the NHS and one which must not be undermined.

The hospital service; general practice, the social

determinants of health and improving co-ordination across boundaries will be addressed in this issue.

The Hospital Service

Is under bigger threat than ever before in the wake of the successful legal challenge against the proposed closure of Lewisham Hospital the government introduced Clause 118 of care to allow Hospitals can be closed after a 40 day consultation.

The NHS in England is faced with wholesale re-disorganisation from above with virtually no accountability to local people.

The South London Healthcare Trust (SLHT) which neighbours Lewisham was a failing hospital with huge debts, mainly the result of the Private Finance Initiative. The private companies charged such huge interest that the trust was effectively bankrupt.

In the first use of the "unsustainable provider" process, a trust special administrator (TSA) was appointed by the secretary of state for health. After a few weeks, he produced a wide-ranging report that threatened the neighbouring Lewisham Hospital , which was thriving and financially sustainable . At present following successful legal challenge to the TSA's plans new proposals are under development.

In the discussions on re-organising hospitals there appears to be a mantra – bigger is better, fewer, bigger more specialised hospitals are the future. This argument was fuelled with examples such as the interventions needed for angioplasty for suitable myocardial infarction (MI) and the reorganised London stroke services. However the recent report on stroke service reconfiguration in Manchester, based on the London model showed no improvement in mortality (BMJ 2014;349;g757)

Angioplasty for MI is a good example of a benefit where better outcomes result from fewer, more specialised centres but does the same hold true for stroke? In Essex attempts to reconfigure according to the London model failed as the ambulance service would not have been able take all patients to the central Hyper Acute Stroke Unit (HASU) in time for them to achieve any benefit over local treatment.

Reconfiguration Choices - what's taken into account?

I attended one of the public meetings on the proposed stroke services in Essex to hear a polished presentation of how stroke care was improved by concentrating services in one centre elsewhere.

Knowing the concerns of many locals about possible downgrading of the A&E departments in hospitals that did not have the Hyper Acute Stroke Unit (HASU), I asked the presenters if they knew how well the A&E departments in the non HASU hospitals were delivering care? Was the enhanced service at HASU paid for by reduced funding to the other units?

The answer was that they didn't know, they didn't know how non stroke services were affected because they were the stroke team.

It is a concern that the stroke services could have been centralised with little thought for the effect on other services.

The conclusion is that the DGHs have had extra funding to upgrade their services so that an equivalent level will be achieved without the need to move services – another example of a good NHS principle at work – generalise best practice – equity in operation.

Is Centralisation a euphemism for service reduction?

The centralists' argument can be a seductive one – a picture of gleaming high-tech machines (beautifully displayed in The Meaning of Life by Monty Python "my favourite – the one that goes Ping"!) with the message you can't expect one of these in every town.

Before deciding on fewer centres we must really establish what the benefits are and at what cost.

For the specialists involved it is good to have more of your ilk – to achieve the critical mass of like minded experts - the academic side is stronger with more people to read papers and to make presentations.

The cost is that patients have to travel further which can affect outcomes and so do their relatives which can complicate recovery.

The simple truth is that most inpatients are elderly (68% of emergency admissions are aged over 65) and so are their spouses and travel arrangements are a frequent problem for the relatives of the seriously ill.

Most hospital admissions do not require high tech centralised services, the commonest admissions, appendicitis, asthma, bronchitis pneumonia, diabetes, heart failure and overdoses can be dealt with in any DGH and with the increasing numbers of elderly with co-morbidities the greatest need is for good generalists. It is good to see that the RCP has recognised this in its Future Hospitals Commission report.

For many patients discharge planning is an issue requiring an MDT to organise care in the community – far better done when the patient is in the local hospital than a distant centre.

Now Clause 118 has been passed we must be alert to the need to defend every hospital – too often we

have heard that centralisation improves efficiency but too often at the cost of local services. It's one of those chestnuts and shouldn't be repeated without rigorous analysis of what will be the gain – preferably measured in meaningful units and at what cost. We have seen bed numbers reduced with the promise of improved community services to follow too often now to believe it.

Common sense, if nothing else says – improved community services first, then the bed reduction will be tolerable. All political parties are now considering merged social and health budgets to enable better community care and to avoid admissions particularly of people with chronic conditions who could be treated at home with more support.

This will be a major structural upheaval as the funding streams have been quite separate with £120bn (and falling) for health going through the Regional Health Authorities and CCGs and £20bn (and falling) for social care through Councils but the logic is convincing and re-uniting the NHS i.e. reversing the purchaser-provider split will be a significant improvement.

There are now encouraging signs of recognition that the reduction in beds has gone too far – at my old hospital, Basildon an increase in bed numbers was seen as essential and a new ward built an opened last year to cope with the winter bed pressures and we avoided the delays in admissions that had occurred before.

Learning From the Mistakes of Private Provision

In my own area I have seen problems and near misses the most relevant to the current situation was the Transforming Pathology project begun by the East of England SHA, several years of planning was meant to produce a new service from 1st of April 2013. They have not delivered and local CCGs were so concerned they completely withdrew and negotiated a better service directly with the provider hospitals. (Described under Perils of Competitive Tendering in the June issue).

This is relevant now because the same team (now Midlands and the East SHA) are handling the bid for cancer and end of life services in the Midlands.

A private agency (Fortis) was employed by the PCT to vet GP referrals to our hospital- this was to save money by reducing the number of referrals and it resulted in delaying diagnoses and treatments. One particular case being an insulin dependent diabetic who was losing weight and had abnormal liver function. Fortis did not pass this on to the specialist but advised the GP to improve diabetic control and order a liver scan. The patient deteriorated and was admitted to my care as an emergency with advanced Hodgkins Disease. A classic example of short term thinking by the private provider resulting in a missed opportunity for cure and saving around £200 for an outpatient appointment at a cost of £tens of thousands for the prolonged in patient hospital stay. Fortis is no longer used by the CCG.

The All Party Parliamentary review of Independent Sector Treatment Centers (ISTCs) showed poor value. Privately owned and run, carrying out a limited range of services with the great bonus that they would not have any emergency admissions to disrupt planned surgery schedules. Also they selected the less complex cases and yet they were 12% more expensive than the NHS equivalent.

The problems of private provision can be illustrated by what has happened in social care Southern Cross Healthcare was the largest provider of care homes and long-term care beds in the UK, operating 750 care homes, before it announced its impending closure in July.

Four Seasons Health Care, which has restructured debts of about £780m, took over 140 homes once operated by the Southern Cross.

Margaret Hodge, the Labour MP who chairs the public accounts committee, said: "Local authority budgets are shrinking and large-scale providers are racking up debt – Four Seasons Health Care, for instance, carries nearly £1bn of debt – yet the department is not monitoring their financial health.

"It is deeply worrying that the department has not made clear what will happen when providers fail. This is crucial to protect frail and vulnerable users of care."

Following rapid expansion, shares in Southern Cross fell 98% from early 2008 to early 2011, reducing its market value from £1.1bn to about £12m. The collapse caused great concern among thousands of care home residents.

Four Seasons was one of the first alternative healthcare providers to come forward offering to take over Southern Cross homes .

In 2009, Four Seasons restructured its finances after the private equity operator Qatar Investment Authority walked away.

A consortium of lenders exchanged half of the £1.5bn owed to them for shares in the business, with the taxpayer-backed Royal Bank of Scotland, the largest investor, taking a stake of almost 40%.

These examples show - Health is too important to be seen only as a business.

ERIC WATTS

Racing to the Bottom

Background.
No, this is not about a keen Proctologist hurrying to work! This is all about the unnecessary, illogical, pointless, endless, NHS reorganisation.

In 2003 the NHS Modernisation Agency set up a series of national meetings under the heading of the, "Emergency Services Collaborative" (ESC). Representatives from all over the UK attended these fora and I was privileged to be one of the representatives from Colchester. The ESC looked at all aspects of healthcare that contributed to the management of Emergencies. Topics ranged from the built infrastructure of A&E to the skills and processes required to deliver a focussed service. The ESC's aim was to galvanise compliance with the 4 hour A&E target!

An item on the agenda.
One of the starters, to whet the appetite for the less digestible parts of the meeting, was a brilliant presentation illustrated by a mythical boat race. It demonstrated the ease with which managers, can destroy a vibrant and well-motivated medical team. Sadly I do not have the amusing set of slides which accompanied his presentation. If he is indeed a member of the NHSCA or any of our members know him, please put me in touch with apologies for plagiarising his story. To this end I have changed some of the associations and nationalities, but the gist of the story is the same.

The Crews.
Crew A was sponsored by US Healthcare with the logo, "The Market Maketh Man". Crew S was mentored by NHS Scotland with the logo, "If it ain't broke don't mend it". The outcome would be to win the race.

In the beginning both crews were composed of NHS doctors, except that the cox of crew A had already been replaced because of a perceived lack of leadership skills and expertise in corporate affairs.

The US team saw the business as potentially lucrative and set out to win by whatever it took. The Scottish team treated the challenge as just another day at the office

Team A indoctrinated their crew in imaginative work practices intended to reprogramme their perception of Coding.

Team S valued common sense, experience and teamwork. They knew that their crew's success would be judged on the quality of each stroke, and not the number of strokes taken.

The Course.
The race was on the river Thames from Putney to Mortlake following the traditional Varsity course. This would be a new experience for both crews. Team A gave their cox a map of the course and lectured the rest of the crew on everything except oarsmanship. Crew S just spent their time assessing the challenges of rowing on the Tideway.

The First Race.
The two crews set off from Putney. The US cox had failed to appreciate the tidal nature of the Thames, how to take advantage of the Tideway's undercurrents and avoid the unpredictable effects of cross-winds. Their crew thrashed at the choppy water like a flock of startled geese trying to escape from an imaginary predator. The smooth style and strength of conviction of the Scottish sponsored crew enabled them to deliver quality with every stroke, and they quickly forged ahead to win the race.

The US lead team regrouped and came up with a stroke of genius!

On examining the relative positions of Stroke (oarsman no 8) and Cox, they concluded that, since these two crew members spent the whole race staring at each other's crotches, Stroke's pulling power and effort could be maximised if Cox was female.

Accordingly the male cox was sacked and a light weight dolly-bird was selected as his replacement.

The Second Race.
When the crews set off the US boat had a new problem. The increased pulling power and enthusiasm of Stroke caused the boat to veer to the Middlesex station (the right bank – looking upstream). This was an advantage over the first mile, but when they had to negotiate the long left hand bend in the river at Hammersmith, their cox had difficulty keeping her boat on course and lost the race.

The US team's next plan was to exploit ways of propelling the boat at the expense of the workforce. They called it "111". Stroke, who had caused their last defeat would be sacked and replaced by another dolly-bird. Her role was to shout "111" whenever the force of the incoming tide or tailwind gave extra propulsion to the boat. In response the oarsmen would feather their blades and perform an air shot. In that way they would save energy for the more challenging parts of the race. Furthermore the removal of Stroke's oar and rigging would lighten the payload.

The Scot's NHS crew found that the experience gained during each race provided them with the necessary continuing professional development not to need to change anything.

The Third Race.
The rematch caused an even worse defeat for the US crew. The team had overlooked the fact that, with four

oarsmen rowing on the bow-side and only three rowing on the stroke-side, the boat would now veer towards the Surrey station (the left bank looking upstream). This helped marginally when they had to negotiate the bend at Hammersmith but after that there was a near beaching opposite Chiswick Eyot. The energy saving dolly-bird shouting "111" intermittently, just made matters worse!

The new crew structure therefore required the removal of one of the oarsmen from the bow-side of the boat, i.e. oarsman no 7. That would also allow the removal of his oar and rigging and further lighten the payload.

But should they leave the vacated seat empty?

If US style leadership wasn't enough, then they would have to sweat the resources and set targets for every member of the crew. To that end a fitness trainer was recruited. He would take the place of No 7!

In order for the trainer to be able to scrutinize the performance of every oarsman he would have to stand in the boat with his back to the dolly-birds. In that way he could offer individually tailored advice every stroke of the way to Mortlake, despite his ignorance about oarsmanship.

The Fourth Race.

The US team, having little knowledge of the factors which determine the smooth running of the boat, failed to appreciate that a crew member standing near the stern, apart from obstructing the view of Cox, would create serious instability. Their performance was a near disaster!

Crew A limped past the post long after the NHS crew had changed and gone home.

The demoralising effect of Team A's repeated interference was clear for the spectators to see. Crew S always went home with a spring in their step and smiles on their faces, whilst Crew A just looked dispirited, not knowing how much worse things could get.

Not deterred by their repeated failures, the US team blundered on without any admission of incompetence. Instability could be solved by increasing the ratio of managers to oarsmen. With a better motivated workforce, encouraged by financial rewards and fearful of swingeing financial penalties, it wasn't necessary to overload the boat with what they thought were poorly performing oarsmen. This would be achieved by introducing special measures (vilifying the workforce whilst empowering the managers) to introduce a succession of replacements and substitutions by people with no rowing experience until the propulsive force of the crew had been whittled away to just one, seemingly highly motivated, person at bow. He found himself perched up at the sharp end of the boat barely able to get his oar into the water. The stern was now overloaded with five heavyweights whose micromanagement skills were in leadership, time and motion, market research, economics, accountancy, property speculation and parliamentary self-aggrandizement.

How could they fail when crew S was so light on management skills and so dependent upon clinical expertise?

Just to make sure of winning the next race, the US team's ever resourceful gurus had one more card up their sleeves. They would choose the date of the next contest. The date chosen was the day after crew S had all been on a night shift.

The Final Race.

The tiredness of crew S was but a minor handicap. They had learned to live with the long hours of selfless dedication to their work.

On the other hand the US crew's schooling, coming as it had from the fleshpots of the city, was not the sort of preparation essential for looking after the wellbeing of others or the success of any form of social enterprise.

The spectators were gobsmacked. How could such a physically unfit crew, apart from the one remaining oarsman, propel their boat anywhere let alone to Mortlake?

The crews paddled around behind the stake boat in anticipation. The US Bow agonised over whether he had ticked all the US boxes and had the strength to take this bunch of management freaks to the finish.

The starting gun blasted off. With just one stroke there was clear water between the two boats. The US Bow knew that he had to dig deep. In fact he dug so deep that he caught an enormous crab. That was followed by an involuntary air shot. Their boat lurched violently from side to side. Water flooded in over the gunwales. Before the spectators had time to catch their breath the US boat had plunged stern first to the bottom of the river.

Conclusion.

You might have thought that with the US's poor track record in healthcare, the gnomes of Whitehall would have paid off the US team, which they had so foolhardily backed, and accepted the fact that the Scot's NHS crew, despite their lack of adequate funding, was a crew worth investing the nation's taxes in.

As they say, "pigs might fly"! The Conservative Party and their hangers on are like dinosaurs that have been programmed up a blind alley of evolution.

The question remains, "has any other political party the balls to do anything other than impose more financial constraints on the NHS"?

MARK AITKEN

Keep our District General Hospitals open

The reconfiguration policies of successive governments since 2000, have at their centre the closure of the District General Hospitals.

There are other big pieces in the jigsaw, which are being put in place through the new powers in the H&SCAct, such as reconfiguring, commissioning and laying the basis for general practice to be organised on the Kaiser Permanente HMO insurance model.

But closing the DGHs is the most urgent requirement for the establishment, as without it, all the elective work cannot be shifted into the new Out- of- hospital community care organisations. Nor can the acute work be sufficiently 'consolidated' into a few distant acute major hospitals and made profitable.

Not content with having run down or closed between 30 and 40 DGHs since 2006, the throttle is being opened to accelerate the programme, by the new head of NHS England (NHSE) Simon Stevens.

Stevens accelerates reconfiguration

In his first major speech on the 4th April 2014, Stevens pledged to accelerate "the redesign of care delivery" and " mobilise for the next stage of the NHS's journey."

This involves closing more hospital beds. He said " the NHS has been developing new services – and closing unneeded hospital beds – since the day it was created." And " our vital interest- as patients and as staff- is in care and health, not bricks and mortar." ' Attaching our staffing to bricks and mortar, and to our traditional ways of doing things has got us into a very ossified set of services." (HSJ 6.6.14.)

And 'it was good that NHS hospital beds have been reduced by 34,000 since 2000 "Absolutely we've got to drive the efficient use of hospital resources and inpatients".

He endorsed NHSEnglands (NHSE) hospital reconfiguration plans in the following words; " Which is why - under the fantastic leadership of Bruce Keogh – at NHSE we're working with commissioners and hospitals across the country to designate 40 – 70 emergency centres, alongside roughly the current number of existing emergency departments." (April 4th 2014)

This is a reference to the November 2013 review made by Sir Bruce Keogh, Medical Director of NHSE, into emergency care, in which he proposed a reclassification of A&E departments into " major emergency centres" and "emergency centres". This said that there should only be 40 to 70 *major* emergency centres in England.

This is defined as a type 1 A&E department with " consultant- led 24 – hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients" At the moment there are 140 non specialist hospital trusts with such departments.

So it appears that Keogh and Stevens are proposing to run down a large proportion of these 140 type 1 A&E departments, and turn them into "emergency departments" only. Presumably these would *not* have 24 hour consultant led resuscitation services and the inpatient beds and facilities to back this up. (HSJ 13.11.13. 'Keoghs plan to re-designate emergency services')

Even Nigel Edwards (Kings fund) remarked " The proposal to introduce two levels of hospital based emergency centre and concentrate specialist services in larger units is sensible but will be difficult to implement given people's attachment to the A&E brand and resistance to changing local services."

Considerable confusion was caused by a BBC broadcast early in June, when some remarks of Stevens were interpreted as a change of policy on closing the DGHs.

HSJ (6.6.2013) clarified the position as follows "Where Mr Stevens has a more significant message is on DGHs, which he believes can be made more sustainable than many have been willing to accept.

"His detailed analysis of what should change to support this includes *overhauling medical training, the use of more generalist doctors, and the ditching of some of the staffing guidance that has deemed some units unfit or unviable.*

One critical issue is that while the DGH ***sites might remain,*** *Mr Stevens clearly envisages quite dramatic changes in the way they work: in his words* ***"complete re invention". That's not the same as preservation"***. (my emphasis AA)

Stevens not only has doubts on the European Working time Directive for juniors, but questions " does our historical assumption hold for all time that just about every NHS acute hospital needs a full complement of trainee doctors to keep afloat?..... what if some smaller hospitals decided on a different staffing model, more akin to some European hospitals?."

This sounds highly reminiscent of the Darzi 2006/7 plan for the abolition of the DGH with the running down of the DGH into something called " A Local hospital". This would be run by 'generalists', and

nurses with few junior doctors, without a level 1 A&E or acute surgery on site, largely looking after medical patients. Acute emergencies arriving there would be shipped by ambulance to the acute major hospital miles away. The Darzi six models of medical care were; home, polyclinics, local hospital, elective centres, acute major hospitals, and specialist hospitals.

Stevens outlined another way to disintegrate DGHs. These could morph into facilities or associated functions of the proposed new *multispecialty provider groups*. Formerly called polyclinics, these are now described by Stevens as " new models of general practice and extended primary care". (They are modelled on Kaiser Permanente HMOs see' Commissioning and funding general practice The case for family care networks' Chris Ham, Rachael Addicot The King's Fund)

"And what if in a few parts of the country – rather than perpetuate the increasingly arbitrary boundary between GP and community-based care on the one hand, and hospital- based care on the other – these health professionals and perhaps even social services wanted to form *new multispecialty provider groups*?" These are also known "*out of hospital providers*".

He told HSJ 6.6.14, *"In some cases its going to mean we're going to have to completely re-invent what we mean by a hospital, by a local hospital.* ***We're going to have to say that the division between what consultants do in hospitals and what GPs do in community settings, that is going to be dissolved.***"

He said, for example, an area would "create a unitary provider group that might take delegated financial risk" and "combined hospital, primary care and community services".

Facts on the ground.

The fact is that since the advent of the coalition government and the about- turn by Lansley on A&E closures three months after the 2010 election, the DGH closure programme has escalated to massive proportions.

There was the fight in SE London to get the entire health services reconfigured in 2012/13, with the use of the Trust Special Administrator regime (brought in under Burnham in 2008) to close Lewisham as an acute DGH. Although the campaigners Judicial Review judgement has held this up, Hunt has now got the law changed so that a decision to close any hospital trust can be rubber stamped by the Secretary of State within six months, even if it is a neighbouring trust that has the financial difficulties. (Clause 119 March 2014 Care Bill)
The TSA regime is now being used for the second time, to close the Mid Staffordshire NHS Foundation trust hospital, in a particularly cruel twist, as it is now functioning well with the increased funding following the staffing scandal of 2008.

£300m has been set aside to put 20 to 40 trusts through the failure regime in the next four years (18.1.14. HSJ)

But in most places NHSE is proceeding with the traditional means of closing DGHs, through collusion between CCG boards, NHSE Local Area Teams and hired management consultants to produce fake and misleading "consultations" and steamroller the plans in.

This is resulting in what MP Andy Slaughter calls the biggest mass hospital closure programme in history in West London, where four out of nine A&Es are being closed.; Hammersmith and central Middlesex on 10th September and the great Charing Cross teaching hospital reducing from 360 to 24 beds with an urgent care centre.

Greater Manchester is suffering a similar catastrophe. But the closures are forging on throughout England Wales and Northern Ireland. Eastbourne recently lost acute services, Withybush Wales, has just lost maternity and paediatrics against tremendous popular opposition, Halifax and Huddersfield Yorkshire are fighting to keep their A&Es, as is Queen Alexandra in Redditch, as are Mid Staffs campaigners who have pitched tents on the hospital lawn all Summer in protest against their A&E maternity and paediatrics being moved up to North Staffs, Newham is losing acute surgical cover. Bedford and Milton Keynes are also under threat of losing acute services. The list goes on.

New weapon of CQC inspections

They also have a the new weapon of closure through CQC hospital inspection.

It is a terrible irony, that Lord Francis allowed his report into Mid staffs to be used to bring in recommendations including inspection regimes, using closure as the ultimate penalty.

In his enthusiasm David Prior, chair of CQC blurted out the truth that the CQC is to be used to facilitate the handover of NHS hospitals to private hospital chains. He said " There are probably 30 hospitals in England that we know have been bumping along at the bottom forever- actually we can name them in a sense, - we all know which ones they are" . He anticipated that by the time all of England's acute hospitals had been inspected in December 2015, a total of between 20 and 30 trusts could end up in 'special measures.'

He said " I know this won't go down well in some quarters, but actually there are some great continental hospital chains as well as great American hospital chains. Why don't we use their management - keep hospitals as part of the NHS - but why don't we attract

them to come over and help us turn around these failing hospitals?"

He cited Circle's 10 year franchise of Hinchingbrooke hospital as a potential model. (HSJ 14.3.14. " CQC chair; 30 acutes could end up in special measures')

This plan has the support of Jeremy Hunt who has appointed Sir David Dalton to lead an enquiry into the plan. ('Dalton to examine barriers to hospital chains' HSJ 13.2.14.)

24 hour elective services to make NHS hospital profitable.

But the privatisers have hit a problem. Talks with Helios the German private hospital chain took place in December 2010 , (Dalton and McKinseys present) to take over the management of London's so called failing hospitals. But the deal fell through, one can only assume, from lack of profitability. Helios has a record of turning round failing hospitals, largely by cutting staff or wage levels. ('German company involved in talks to take over NHS hospitals " Guardian 4.9.11)

Not withstanding that the H&SCAct March 2012, allows for 49% of a hospitals finances to derive from treating private patients, the private sector is not interested in running NHS hospitals until the 7 day elective working of medical staff can be guaranteed so as to "sweat assets".

Sir Bruce Keogh said (Dec 2012) " : If you wanted a day case operation, and you didn't want to take a day off work , why can't you have it on a Saturday or a Sunday? The rest of the commercial world were taking a different approach he said. "Tesco had to go through this – it was a complex issue for them- we need to look at the terms and conditions of people." He said having empty clinics and operating theatres on a Saturday and Sunday is a waste of NHS resources.

Apart from the fact that he clearly hasn't a clue about the use of operating theatres for emergency cases at weekends, the intent is clear to get consultants in the hospitals seven days a week doing routine work.

Keogh has repeatedly emphasised that enforcing seven day elective working on the medical profession is his immediate goal. He wants a deal done by October 2014.

This means the destruction of the current 2003/4 consultant contract.

This was apparent at the BMA's 2014 Annual Representative Meeting, in the speech of the replacement head of the BMA consultants committee Tom Kane.

The committee is having its arm twisted to remove section 3, para 6 of the Consultants contract which states " " non-emergency work after 7pm and before 7am during weekdays and at weekends will only be scheduled by mutual agreement between the consultant and his or her clinical manager." At the moment elective work after seven and at weekends has to be agreed with the consultant, and commands pay at time and third.

The scrapping of this clause would allow scheduled planned elective work, such as outpatient clinics and operating lists to be performed after 7 pm in the week and on weekends at basic rates. A five day week would be staggered over 7 days to cover weekends, with time off in lieu in the week. Once agreed by medics, the floodgates would be opened for the rest of the million strong NHS workforce.

This policy is being disgracefully put across to the public by the government and NHSE as a desire to improve emergency care at weekends - propaganda belied by the closure of hospitals, A&E departments, huge cuts to beds and ambulance services and the dangerous progressive reduction of on-call junior cover.

It is clear from his 4.4.14. speech, that Stevens is acutely concerned to change NHS staff working practices. He refers to this obliquely as follows. " In our heart of hearts we know that, despite the theoretical flexibilities offered in Agenda for Change, today much work has been assigned to the " too difficult" box. Its good to see NHS employers, Health Education England, and a number of medical royal colleges all now beginning important work in this area."

Stevens is on record as supporting local pay agreements.

What we must do

Our NHS was founded as an integrated public service in which planning for all was on the basis of patient need and services collaborated to this end. The backbone of the service is a publicly trained and employed work force with national terms and conditions. It is this they are coming for in the broadside for "7 day working".

We have only to cast our eyes across to the mayhem in outsourced social care and ancillary services, to see the abyss of agency style work patterns and cheap labour, which they have in mind for the future of privatised health services.
The NHS, made it possible for the first time for the mass of the population to access specialist consultant-led hospital services.

It is clear that this forced march of reconfiguration and " journey " to American style privatised hospital

chains and HMOs, will remove access to consultant led hospital services for the working class. This is the meaning of the DGH closure programme.

The key issue facing us as NHSCA members is how the DGHs can be defended and re established.

Local campaigns have striven through petitions and lobbies and marches and local and some national campaigns to stop this onslaught, but we are up against a state organised conspiracy with massive funding and all the expertise of the US management consultants.

There is only one power in the land that can defend our hospitals and that is the organised trade union movement. The unions must organise united industrial action to stop the closures, restore public ownership and bring in a workers administration.

Unfortunately Labour has no policies for the defence of DGHs and a new type of socialist government is needed which will restore our DGHs. This would go hand in hand with revamping our GP surgeries as a public service, and nationalising the drugs industry and all associated industries to bring out about a renewed socialist NHS on a much higher level.

ANNA ATHOW
(retired NHS consultant surgeon)

Meeting With Andy Burham

On 8th July an NHSCA delegation consisting of Wendy Savage, Jacky Davis, Chris Birt, Eric Watts and myself met Shadow Health Secretary Andy Burnham and had an hours exchange of views.

We confirmed our support for repeal of the H & SC Act but insisted it should be seen as the first step to removal of all elements of the market in an incremental way, not another major reorganisation. AB said that Labour planned to have a bill for repeal of the Act in the Queen's speech. He also raised the topic of Clive Efford's Private members Bill, the details of which are still being drawn up but the main elements will be:-

- Restoration of Secretary of State's duty to provide a comprehensive service
- Removal of Section 75
- Removal of Monitor's role in promoting competition and of the Competition and Marketing Authority
- Restriction of Trusts' private income to previous levels

The first reading will be in November and it is hoped that there will be sufficient support from non Labour MPs to keep the debate going and the topic in the news for a prolonged period

AB commented that there were many divisions in the current NHS and in particular between primary & secondary care and he saw opportunities for DGHs to reach out more into their communities". He spoke of his desire to see the integration of Health and Social Care, with Health and Wellbeing Boards playing a key role. Whilst supporting the general principle we pointed out that there would be many details to sort out. One that had caused concern was the risk that, with Health being free but Social Care means tested, this could be a way of introducing charges for Health. He acknowledged this but felt that it would work the other way, with gradual reduction of charging for Social Care. We also warned that this could open the way to something like HMOs but he agreed that funding and responsibility must be for a geographical area, not for only those registered.

On wider public health issues, AB stated that there remain many policy areas where decisions have not yet been made by the Party. For example, there is no decision yet on whether to restore nutrition powers and responsibilities to the Food Standards Agency. However, AB emphasised the need for action on children`s food, and the relative merits of regulation and taxation in support of public health policy were discussed – he favoured regulation. We also stressed the need to restore the independence of public health professionals, and he stated his intention to achieve this through statutory means.

He was asked what Labour would plan to do regarding the crisis in Primary Care. Whilst acknowledging the problem, particularly in the light of a desire to have more care delivered outside hospitals, no definite answer was forthcoming although he favours moving towards a salaried service.

At the political level we pointed out that a clear statement of intent to restore the NHS to its original principles would have massive public support. He was reminded that we are a non-politically aligned organisation but at the same time we want to see a major change of health policy and will do all we can to ensure that comes about. We would therefore be keen to continue this dialogue and discuss practical steps that can be taken to achieve our aims.

He promised to make arrangements for us to meet Clive Efford MP to discuss his Bill

PETER FISHER

Exclusion of Doctors from work in the NHS
Time to ask questions and take action

An article entitled 'Surgeon wins fight after NHS cover-up' in a recent edition of The Sunday Times (1) caught my attention. The surgeon concerned had complained about unclean operating theatres and inadequate equipment that led to the death of one of his patients in 2010. The surgeon was subsequently sacked in 2012. A tribunal hearing earlier this year concluded that disclosures relating to the death of the patient "were a material influence in the decisions ….to subject him to disciplinary investigations".

The above report appeared soon after another case of unfair dismissal was reported on BBC news and subsequently reported more fully in The Telegraph – "NHS faces £20m bill for sacked doctor" (2, 3); a cardiologist had been suspended for eight years and then sacked in 2010. In April this year, a tribunal ruled that the cardiologist was unfairly dismissed.

The above reports prompted me to undertake a search of the internet, which revealed numerous cases of unfair exclusions, suspensions and dismissals, not all of which received exposure in the national press (4, 5, 6, 7). The web site of the Department of Health did not have any record of such events. Conversations with colleagues from different parts of the country suggest that exclusions and suspensions are not uncommon and are often settled out of court, thereby avoiding any public disclosure.

Startling figures -

The only formal record of exclusions and suspensions was the report of the National Audit Office of investigations conducted in 2002 – 2003 (8). During April 2001 and July 2002 over 1,000 clinical staff were excluded from work, and the period of such exclusions averaged 47 weeks for doctors and 19 weeks for other clinical staff. Doctors made up one fifth of all exclusions. 40% of doctors and 44% of other staff returned to work. The report calculated that the annual cost of exclusions was £29 million' the average cost of excluding a doctor was £180,000, and the cost for exclusion of doctors accounted for three quarters of all costs.

Whilst the annual cost of exclusions and suspensions is a disgraceful waste of the tax payers' money, the other effects of these need to be seriously considered.

Not being able to work will result in the doctor being de-skilled, making it even more difficult for the doctor to be rehabilitated into a safe and useful practice if and when the individual returns to work. Failure to return to work is a sad loss of experienced human resource.

There is immense loss of self esteem, profound anxiety often combined with anger, and may lead to suicidal thoughts. The negative effects on the families must be profound. For those of us who have been fortunate not to have been excluded from work, it must be difficult to imagine the depth of despondency of such doctors and how this impinges on the affected families. How can one judge the effect of loss of one's ability to work and thereby be unable to earn a living to maintain one's family? Often, these unfortunate events lead to complete loss of one's assets and life savings in the pursuit of justice. It is worth quoting Professor Wendy Savage (9) – "The loss of my job was like bereavement. Powerful, confusing and shifting emotions swept over me – disbelief (can this really be happening?), sadness, guilt, self-doubt and anger."

Compare the above with what happens to those people who instigated the exclusion process: do they suffer? There is no data on what happens to management in the event of a doctor being found to be not guilty. There is a suggestion that such people often get promoted and may well be recipients of large bonuses; in the absence of any data, one wonders what adverse effects do they suffer. This must surely be unfair and unacceptable.

We work for a service which cares for people and health professionals are caring people. Yet, the NHS and the system continue to subject clinicians to long periods of being excluded from work, often without any evidence, resulting in the most damaging effects on such individuals, loss of human resource and a waste of our money.

It is time that information pertaining to exclusions and suspensions of clinicians are publicly available. It should state the reasons for such actions, the outcomes, whether the clinician returned to work, and what actions were taken against the instigators in the event of the clinician being found to be not guilty.

As members of a caring profession we must surely accept some responsibility in identifying and reporting incidents when staff are exclude from work. Perhaps,

all hospitals should be legally required to report all such incidents to an elected local group of senior non-management clinicians tasked with overseeing the events and guiding the affected clinician.

Individuals acting on their own are rarely effective in bring about changes within systems. Only if we organize ourselves as a group will we be able to mount an effective campaign. Perhaps, NHSCA could start the ball rolling by inviting other professional groups to join with us as one group to demand the transparent publication of data pertaining to exclusions and suspensions.

ARUN BAKSI
Consultant Physician

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Dying for a drink?

Bold statements about alcohol intake are made by medical, governmental and sociological spoilsports, almost always unsupported by the evidence base which is supposed to underpin practice and advice. For example, admissions for gout may indeed have almost doubled in the last 5years, but is hard to explain this by increased alcohol consumption (Times, July 2014), as this is known to have shown a sustained moderate fall in the last 10years in England & Wales. This applies both to official figures for drinking at home and on licenced premises, though it cannot measure illicit hooch, which has always been with us.

Recommendations on desirable ceilings for amount and patterns of drinking are arbitrary, as the official statistician pointed out when the Government first published them. They keep changing in a most confusing way, and are ever more stringent. There is no real proof that particular levels are safe in all circumstances. However, modest intakes have repeatedly been shown to be linked to a longer life expectancy and protection from ischaemic heart disease,(and also reduce gallstone disease!).

There is widespread misunderstanding of the history of alcohol intake in the UK. Accurate figures for excisable ethanol are available from 1684, and can be linked to population data to calculate individual consumption. This was hugely greater than today in the 18th& early 19th centuries, when water was often of poor quality or downright dangerous . It showed a progressive decline over 250years. This paradoxically slowed in the late 19th century, when the Temperance movement was active. Consequently 1950 was about the lowest point ever, but always seems to be taken as the reference point by doom-mongers reporting subsequent changes. There was an increase over the next 50 years, but figures in 2000 only reached levels seen before in 1900. The overall effect over 3 centuries produces a graph a bit like a reverse correction mark. However, life expectancy has continued dramatically improving since 1950 (by 1 year every 4-5 years survived), so we must be doing something right!

As Edmund Burke may have said, but did not write, "For the triumph of evil it is only necessary that good men do nothing". Doctors do have a duty to tackle alcohol abuse, as it leads to addiction and physical health problems. Public support has already made drink-driving socially unacceptable, and could be mobilised to address public drunkenness and disorder, binge drinking and alcoholism. Making alcohol less freely available (especially at motorway service areas and petrol stations), and banning promotions based on price as already happens in Scotland should hardly be objectionable. There is no obvious social benefit from advertising alcohol brands any more than cigarettes, and this should be similarly restricted. Likewise the general increase in late licences, encouraging drinking into the early hours, has not been useful as it leads to a need for police supervision at unsocial times. Increasing minimum prices seems reasonable, is known to be effective, and is possible via the tax system without needing fresh legislation; it does have opponents, though.

Intemperate assertions about alcohol use by the healthy are unhelpful, as they tend to be treated sceptically, and antagonise the overwhelming majority of citizens who are moderate drinkers and whose support is needed to make real progress.

MALCOLM BATESON

The AGM and Conference 2014

is being held in London on Saturday 4th October at **Hinde Street Methodist Church Hall, Marylebone**

It will be a particularly important AGM due to proposed changes in the Association reported earlier in the Newsletter and also being the last one before the General Election.

Details of the programme and application forms were sent to all members in mid August but if any have gone missing further copies can be supplied from the address below.

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