DOCTORS FOR THE NHS
SERVICE NOT PROFIT

NEWSLETTER

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Editorial:
Handcarts in convoy

Despite 70 years of continual old-testament-worthy predictions of terminal melt-down, the NHS won't do that, just as it hasn't since 1948. We'd do well not to proclaim its demise – a ritual pronouncement every winter. But its foundations continue to be eroded in ways that only intermittently make the headlines. Without seeking out trouble – or even information, for that matter – in the past couple of weeks several of the demons gave me a good nip.

Juniors on the streets

On Sunday 15 November, we were in a warm and relaxed Birmingham, and spent a few hours in the splendid German Market that spills down from Victoria Square all the way along New Street, and which has become a traditional pre-Christmas event. At the station end of New Street (the station itself has become yet another dreary white shopping centre with a few train platforms attached) in the middle of a very large crowd of good-natured beer-drinking and frankfurter-chomping Brummies was a large rally of about 200 juniors demonstrating, quite undemonstratively, their feelings about the new contract, that nice Mr Hunt, and other related matters.

I didn't spy too many obvious Trots or anarchists. They were nicely scrubbed and rather well turned out and (as someone else pointed out when they highlighted the high-risk government strategy of targeting the juniors) very definitely neither on the golf course nor seeing private patients. I spoke to a couple of foundation year doctors. They told me of their concerns for patient safety, their insecurity about their long-term futures, and the instability of their organisations. By the time this is in print, they will either have become the 2015 equivalents of the miners under Mrs Thatcher, or preferably will have ensured that the race to demean professionals to the status of the lowest currency of human capital may have slowed a little.

PFI, PF2 – and counting

Though I no longer do acute medicine, we all need our CPD notches, and the Acute and General medicine conference at ExCel is usually a good two-day update for physicians of all generations. The adjoining exhibition is nearly as interesting as the lectures. There were at least 20 trusts displaying their wares in very smartly appointed stands, all adorned with rural lifestyle photos. The reasons for these conspicuous displays of ostentation were frequently less clear than the dreary slogans they displayed, usually a random mixture of "opportunity, innovation, exciting, nice schools, only 2 hours from London when HS2 arrives, join our happy team" – the usual depressing PR-speak.

Interestingly, many of the trusts were – though you'd never know it looking at the pictures of happy-clappy healthcare professionals – in special measures or otherwise engaged with the CQC, so were obeying the management-consultant mantra of smiling especially broadly when you're in your death throes, and hoping that some people might not notice (actually, I'd be interested to know how many prospective consultant candidates are properly informed of the real significance of the CQC status of the dying organisation they may be joining for the next 40 years).

I spoke to two nicely presented young people, presumably managers, or possibly press and comms people, in front of a lavish scale model of a new hospital called Midland Metropolitan. We are encouraged on the hospital website (definitely virtual, as it doesn't open until 2018) to call it much more coolly "Midland Met", which has a laid-back, slightly North American twang to it, presumably fully intended, and of course it will be a hospital "Where EVERYONE matters". It will replace a handful of large hospitals near Birmingham including Dudley Road, Smethwick and Sandwell.

So PFI is alive and well, I suggested. But this, the young lady told me, is PF2. In what ways does that differ

from PF1? Wasn't quite sure. I prompted this eager young person with tangential questions like how much the glass-covered cockroachy-looking thing would cost to build (I suggested the usual "DGH" cost of £350m or thereabouts – they demurred), and more importantly, the interest rate on the loan (and indeed the term of the loan). Didn't know really. But they were up front that because of new ways of working and transformative innovation (or it may have been innovatory transformation) they needed fewer acute beds than the hospitals it was replacing. Ah, yes, I said, that was one of the characteristics of PFI that seems to have been translated unchanged into PF2. Casual question, then, by how much would the bed-base be reduced? 10%, 20%? They were coyly ignorant of all these matters.

The Midland Met website has a jaunty Q&A section, and the PFI question is handled with consummate mendacity, using exactly the arguments DFNHS members have been hearing for nearly 20 years:

"Q. The new hospital will be built under PFI – should I be worried?

A. No. The new hospital will be built under Private Finance 2. Crucially that means that key services like portering and cleaning will remain within the NHS. The financial model for the new build has been assessed by the trust, the Treasury and the Department of Health, as well as other NHS bodies. It is affordable, and the cost proportionate to the turnover of the hospital trust is far lower than some PFI schemes from the early part of the century. Of course, new facilities cost. The existing hospital facilities are over 100 years old in some cases, and the cost of bringing them consistently to basic statutory standards is over £100m."

(£100 m for a full refurbishment seems like good value, compared with the total PF2 cost. The refurbishment option must always be considered, and is ritually dismissed, so presumably the need for clever accountancy is another thing that hasn't changed in PF2.)

Failing the final duty

Then, a personal and poignant piece in the current 19 November issue of the *London Review of Books*. The novelist Jenni Diski is dying of lung cancer superimposed on longstanding pulmonary fibrosis, and is writing a series of articles. She has been introduced to the hospice. She felt that she would benefit from a week's respite in the hospice, but because of her severe depressive state would have preferred a room to herself. Promises to fulfil both these requests were twice given her, but when she pitched up there was no single room, and she was reminded that the hospice doesn't do respite. They couldn't even guarantee that she would have a single room when it came to her final admission.

No clinical negligence, no lack of communication, nothing that would register with the CQC. Just non-decent care that is increasingly at variance with the sloganizing mantras of holistic care, mission statements, and repeated and empty promises to keep the customers happy and scoring us highly on the Friends and Family Test. Many, but sadly not all of us, have honourable intentions of keeping those promises.

Commission omission

Finally, the shadowy world of conflicts of interest in CCGs, widely suspected, and now exposed in the *BMJ*. Twenty years of false reassurance about the watertight supremacy of the neoliberal quartet of "governance", guidelines, audit and compliance has led to a morass of just-about-legal arrangements that any non-expert would immediately spot as fairly stinky if they were exposed in banking, but a few hundred million here or there in the NHS doesn't seem to be the same.

Actually it's much worse. The side-bar quotes from leading doctors miss the herd of elephants with their howitzers. Clare Gerada: "We've got to be careful that it's the patient's pulse we're feeling, not the patient's purse".

Clare, unusually, seems to have been misquoted: we're ignoring the bulging purses of some commissioners. Sarah Wollaston MP, a GP new chair of the health select committee, and someone who should know better, still seems to think that world-class commissioning (remember that?) is intrinsically right and even more strangely, good for patients. A little financial irregularity is a price well worth paying for world-class care: "The trouble is if you have a blanket ban on CCGs commissioning from organisations where GPs have an interest then you might lose something that gives patients the best care."

Four events that I didn't seek out: commissioning to palliative care, PFI to rotting "human resources". All different Rorschach blots. The pendulums have swung a long way from unconflicted care.

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General Practice: On the Brink?

Things are not good in general practice at the moment. Over recent years we have seen year-on-year systematic reductions in overall funding to general practice. This has been a cold, calculated tactic and due to political decisions made at the highest level. Some say it is being done as 'punishment' for what was perceived as an over-generous contract deal in 2004. In fact Jeremy Hunt even said as much at a recent conference [1] – much to his shame

Mr Hunt has recently had to handle the issue that his misguided decisions caused: 98% of junior doctors in England to vote for strike action – unprecedented in more than two generations. Yet his actions – driven by ideology, not evidence – also threaten general practice with calamitous collapse, to the detriment of the profession and the public alike.

All in the name of "marketising" a system that never needed it, never wanted it – and was certainly never voted for.

This is not a new problem but is becoming a critical one. In 2004 general practice was in a bad place and needed extra funding. We have now slipped back to an even worse situation.

At one time funding was over 12% of the NHS budget for general practice whereas now it is around 7%. To halve the funding clearly will have dramatic effects on the service offered.

Those of us working every day in our surgeries see the effects of this. GPs are burnt out, leaving the profession, suffering mental illness, having to close their practices as they can't recruit doctors or nurses and some are going bankrupt due to all this.

General practice is desperate for more funding to prevent its collapse.

> What the NHS needs is more funding...it has had flat-line funding since 2009

We have the perfect storm of falling recruitment and retention. Doctors are no longer attracted to a career in general practice given all the negativity they read in the press and what they hear from colleagues. GPs in their fifties are desperate to retire as soon as they can and often leave many years earlier than they would have done. Very experienced GPs are then lost to the NHS.

Workload has rocketed with many GPs working 13-14 hour days and dealing with upwards of 60-70 patients a day. This is neither safe nor desirable from the point of good patient care.

What the NHS needs is more funding. It has had flat-line funding rises just above inflation since 2009 along with a political drive to save (cut) £30bn from the budget. No health economy has ever successfully done this. Why are politicians demanding this? Surely they will know it will decimate the service, drive doctors away, diminish patient care and leave the NHS struggling to cope – all things we see already.

Many feel it is deliberate in order to diminish the service and push through the sale of more NHS contracts and services to the private sector. The UK is a rich country. We can afford the NHS and we can afford to increase its funding dramatically. Politicians have decided not do so.

Why not have a windfall tax on Google, Amazon or Apple so they pay adequate tax in the UK? Why not hypothecate tax from the tobacco or sugary food and drinks industry to fund the NHS?

The answers are there – it just needs the political will to do it.

These circumstances have led to the BMA General Practitioners Committee (GPC) to call a 'Special Conference' – in effect a crisis

conference due to the parlous state of the service.

The last time a 'Special Conference' was called was in 2003 when a new contract was desperately needed to shore up the then failing service. GPC have called this conference for January and GPs from across the UK will come together on Saturday 30th January to debate what action is needed to save our profession. It may even decide what action GPs are prepared to take to save our profession.

Some talk of undated letters of resignation, some of resigning from NHS general practice and some of refusing to comply with the ludicrous demands and costs of the ever-growing quango that is CQC. GPs have to fund this inspection now and the average practice will see fees treble to around £10,000 soon. That is £10,000 that could go towards funding another nurse or member of the admin team in a surgery.

There are so many attacks on the NHS across many fronts and the profession must unite to protect those who work in the NHS and to protect the service itself.

If politicians continue down the current misguided policy route then the NHS as a publicly funded, publicly provided and publicly accountable service could be a thing of the past.

Reference

[1] Pulse (2015) [online] available at: http://www.pulsetoday.co.uk/your-practice/practice-topics/pay/gps-unfairly-punished-on-funding-bma-tells-ddrb/20030248.fullarticle

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Seizing the Pump Handle: The Meaning of Politics

The Junior Doctors' dispute must be seen in a wider context

We all know the tale. Dr John Snow, on linking the outbreak of cholera to a contaminated well in Soho, London, in 1854 persuaded the authorities to remove the pump handle. Heroic genius saves the people. The first example of someone working out how cholera was transmitted, and taking steps to prevent infection.

Except he didn't. Snow himself admitted that the outbreak may well have been in decline anyway by the time the pump was rendered useless. But that isn't what the myth says; as powerful a demonstration of the truism "never ruin a good story with the truth" as you could wish for.

The point was, there was a deeper principle to Snow's actions. That of acting in the public good. Something we as doctors have always done. By demonstrating the idea (that cholera was transmitted in water) with concrete actions (removing the handle), the principle was both demonstrated and believed in.

Was this a political act? Of course it was. Removal of handles is not in itself a treatment, and a whole population was Snow's concern. As doctors, our principles allow us to act in the public good just as resolutely as when treating an individual patient. Acting to reduce health inequalities fits just as strongly with that as removing pump handles.

Why is it, then, that our recent actions in defending standards of safety and fairness in the work we do – surely as clear an indicator of preventing harm as you could wish for – have been criticised as being "political", or "too political"?

I sit on the Junior Doctors' Committee at the BMA. The sheer scale and iron will of the protests by my colleagues, sparked by this government's arrogance in applying a change to our contract that would create unsafe and unfair practice as the norm, has been inspiring. But all too often, at the highest levels of the BMA, over the last year, I have encountered the view that we should not be overtly politicised and that "we do not seek to change governments but to change government policy with equal vigour towards all".

> The sheer scale and iron will of the protests sparked by this government's arrogance...has been inspiring

My attempts to reach out to other unions, for example, have been perceived as dangerously political. Any attempt to clearly describe the fact that our present junior doctors' contract dispute is embedded within the politics

of austerity has also been decried as too political.

I would also add that being political is regularly conflated with being in "party" political alignment. This is not the case.

In my view there is also no escaping the fact that debates around the NHS more generally have been at the centre of political discourse. This can be seen at a number of levels:

1. The NHS regularly tops polls of the public's view of how important various political issues are.
2. It is at the centre of the debate both between the political parties vying for power and at the centre of debates within those parties.
3. The NHS is the cornerstone of the twentieth-century's social democratic consensus. This is the very reason why it is under systematic attack. "Social democracy" as a concept has been attacked and undermined systematically with the rise and prominence of neoliberal hegemony [2]: the real driver behind the government's intentions towards our NHS.
4. For many formerly apolitical junior docs concerns over a privatised NHS have come to the fore during the present contract dispute.
5. Deficiencies in health and health systems both domestically and globally exist for political reasons (examine the West African Ebola epidemic, the present health crisis in Greece [2] and health inequalities in the UK [3]).

And we can't wish all this away. Why? Because it is of course natural that this politicisation should be the case; the NHS is by a wide margin the biggest employer in the country (and fifth biggest in the word) and it is one of the biggest branches of Government in Funding/Financial terms.

Given the facts just stated and given the need to respond to the global Financial Crisis of 2008 in a certain way; the government has no choice but to politicise the health service by driving through neoliberal "reforms". And the proposed junior doctor's contract is straight out of the neoliberal play-book! As was the Health and Social Care Act 2012.

The BMA's reluctance to "get too political" is now resulting in the impasse which we in the BMA find ourselves. I cannot of course go into the detail of that decision publicly but what I would say is this: the BMA finds itself in a tough position. Our negotiations with Hunt have been "triple-locked" in my view. And we as a union and as a movement need to find a way to break through each of those "locks".

The first of Hunt's safety locks is the pernicious DDRB report and its modified "November proposal" form [4]. The second safety lock is the time-frame of likely imposition. And the third safety lock is the "neutral pay envelope" and expansion to a "7 day NHS" (in the context of cuts to NHS funding)… in a word: austerity.

To repeat, we in the BMA have to break through each of those "locks" if we are to have any chance of achieving a safe and fair contract. And we won't be able to break through those locks alone. To unlock the trap will take overtly political actions with rigorous, ethical principles of the public good driving them. In particular:

- For other groups, such as Doctors for the NHS, to keep things political: to do and say that which the BMA cannot (or chooses not to!) do, and to ensure that doctors, other health workers and public are educated about what is at stake.
- For unions, health workers and campaigning groups to link together and work in a common defence of the NHS.
- To make the reasoned, objective argument that it is indeed the conservative ideology itself which is absolutely devoted to destroying the very existence of a safe, efficient, publicly funded, publicly provided NHS.

We must cease to be bound by simple assertions of becoming "too political" – in themselves, nearly always political statements geared to preserve the prevailing political view. Only by continuing to engage with each other and the wider public can we fight the greatest attack on public health: the undermining of our NHS.

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[3] Peedell, C. (2011) Global neoliberalism and the consequences for health-care policy in the English NHS. In Europe's Health for Sale (Lister, J, ed.). Faringdon: Libri. Chapter 8.
[4] Department of Health (2015) Review Body on Doctors' and Dentists' Remuneration 43rd Report: 2015 [online] available at: https://www.gov.uk/government/publications/review-body-on-doctors-and-dentists-remuneration-43rd-report-2015

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The Nightmare Merger That's Now Just a Routine Bad Dream

"There are two things that are infinite: human stupidity and the universe – and I'm not sure about the latter"

Albert Einstein

Positive note: the disastrous Barts merger in 2012 that created the largest Trust in the NHS (Barts itself, the Royal London, Newham, Whipps Cross and the erstwhile London Chest), at least prevented an even bigger catastrophe – the merger of Kings, St Thomas' and Guys which was being considered around the same time.

The CQC, inspecting Whipps Cross towards the end of last year, found – hardly surprisingly – that the loss of some 250 senior nurses in the clearout after the merger had impaired its functioning, and lipsmackingly placed the whole of Barts into special measures.

But it was the financial catastrophe, with a predicted year-end deficit of £140m (up from about £90m in the Spring), that finally precipitated the departure of the finance director, closely followed by that of the CEO, Peter Morris (salary c.£270,000), the Chief Nurse, Professor Kay Riley, then the Chair of the Trust, and finally, Steve Ryan, the Medical Director, all of whom have left to pursue new careers in areas they, of course, always really wanted to do, usually education.

It was the medical director, proclaiming his YouTube vision of the healthy East End from the rooftop of the new Royal London Hospital (total PFI cost, together with the new Heart Centre, around £1.5bn) who claimed 3 years ago that the deprived people of East London deserved this merger. No they didn't. Wildly successful, the video has had just over 600 views, and it's well worth another look, but only if you have a cast-iron gastrointestinal constitution.

One other luminary deserves a mention: the Director of 'Turnaround' at Barts, Donald Muir, whose management consultancy earned £1.4m in about 9 months before he quietly departed in the middle of 2014, having evidently given a new meaning – and a wholly new direction – to the concept of Turnaround. Please let me know if DFNHS members have any further sightings of this serial failure being employed elsewhere in the Health Service.

A letter sent during the summer to Simon Stevens and signed by 80 Barts consultants (a very small proportion of the 600 or so employed by the Trust), naively requesting the PFI debt to be cancelled (like the banks, they said) would have been better directed towards the Health Select Committee, demanding an inquiry into the fiasco.

Unfortunately, the tigger-like Margaret Hodge, Chair of the Public Accounts Committee, has been replaced, and the Health Select Committee under Conservative MP Dr Sarah Wollaston is unlikely to significantly rock the boat (doctors brought into the big tent – with a very few honourable exceptions – are well-meaning but politically wet behind the ears and usually end up as playthings for whichever neoliberal administration's in power).

Public scrutiny and even rational critique of these cataclysms is likely to be timid or non-existent for the next 5 years.

Because the Trust Development Authority (TDA, in charge of non-Foundation Trusts) and Monitor still report separately, it isn't easy to get a picture of where things are at present, other than the headline projected £2bn deficit announced a while ago. But 72 of the TDA's 90 Trusts were in deficit at quarter ending 30 June 2015. Thirty-seven Foundation Trusts are subject to 'enforcement action', and 8 remain in special measures, now, disgracefully, including Cambridge University Hospital – a clear indication that the CQC inspection regime and its battalions of box-tickers are foolish and probably knaves.

To add to the confusion, 29 FTs in October were reported to have a 'continuity rating' of 1 – the most serious level of risk that the Trust 'will fail to carry on as a going concern'. Oh – and of course, there's a 'governance' rating as well indicating Monitor's view of their degree of concern about the running of the organisation. Clearly this fluid series of arbitrary judgements will continue, probably intentionally, to fuel widespread uncertainty, and blight recruitment, especially to Trusts in special measures.

Special measures, therefore, are no longer very special, so wielding the 'governance' whip and the 'financial austerity' cleaver must be delivering diminishing returns: if everyone's in financial meltdown, and breaching hitherto line-in-the-sand targets is the norm, where can the sanctions lie?

But we have been here before, and with each crisis our politicians become more, not less, wily in their ability to contort language and meaning.

They are also not thick-skinned enough to pursue evidently politically high-risk strategies like the dismal Barts mega-merger. Surely they can

see where they are heading: but can we?

Perhaps one answer is given by Peter Roderick, colleague of Allyson Pollock, and co-drafter of the NHS Reinstatement Bill. He writes in the current, 3 December, issue of the *London Review of Books*.

"This small-print stuff, in this case from the 2012 Act, is the very essence of neoliberal quasi-legalism; it revolves around a three-year agreement between Monitor and foundation trusts to provide so-called 'Commissioner Requested Services' (CRS). These are the currently provided services commissioned by CCGs, but the requirement to provide them expires in April 2016, based on the outcomes of envisioning the financial failure of Trusts, who would thereby no longer be in a position to provide continuity of these services."

Presumably through this process, which is nearly completely opaque to anyone without a law degree, the large number of financially-challenged FTs will be able, probably strongly encouraged – and possibly forced – by Monitor, to ditch current core services, though presumably not – Peter doesn't mention this – emergency care.

Regardless of whether this comes to pass, we can envisage a whole hierarchy of boilerplated processes based on the 2012 Act that can be invoked with a primary aim of reducing the General Hospital to a minimal emergency care-based institution with patients being despatched to a motley crew of providers once their acute care is deemed over (and they have given a five-star TripAdvisor/Friends and Family Test result to the Costa outlet with a skeletal hospital attached).

Cappuccino rules.

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Some More Thoug Manslaughter and

The excellent conference on manslaughter in the context of medical practice, reported in the June issue of this publication and which I also attended, arose from the realisation that there was an increasing number of criminal prosecutions where previously there may have been only a coroners' hearing and possibly a related claim in negligence.

> "When doctors' actions result in death it might be from a criminal level of negligence"

The coroner's only duty is to investigate who was the deceased and how, when and where they came about their death; but coroners (and relatives) can inform the police where they feel that the circumstances leading to that death may merit a more detailed investigation.

Dynamap error: Adomoko

In 1995 the unfortunate Dr Adomako took over an anaesthetic from a colleague. Subsequently, during the course of the procedure the endo-tracheal tube became disconnected. The first indication of this to which Dr Adomako responded was 4 minutes later when the Dynamap alarm sounded. He gave atropine but 5 minutes later the patient suffered a cardiac arrest and only then did Dr Adomako discover the disconnection.

The court was told he could and should have noticed that the patient's chest was not moving and, although its alarms were not switched on, that the ventilator's dials were not moving. Further, he misinterpreted the Dynamap alarm as a malfunction and failed to notice a fall in the patient's pulse rate.

The expert advice to the court felt that he should have noticed the disconnection of the e-t tube, let alone any of its consequences, within about 15 seconds. Dr Adomako's negligence was not in doubt but were his actions and inactions sufficiently serious to warrant a criminal sanction?

He undoubtedly owed a duty of care to his patient and this he had failed to discharge but did that amount to a crime.

Dr Adomako unwittingly set the standard for gross negligence manslaughter in the context of medical practice.

He bore the patient no malice and had not intended to kill him but was his breach of duty in failing to give his patient proper, skilled care, and its consequences serious enough to constitute gross negligence and how should that be decided? Should he be judged criminal?

In his summing up Lord MacKay said that if undertaking the task in the first place he must be expected to exhibit

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the appropriate level of skill involved but "not necessarily the great skill of the great men in Harley Street", he added deferentially. He thought that the word "reckless" was helpful in reaching this decision.

Misjudged infection: Sellu

In 2012 Mr David Sellu was asked to review a patient in a private hospital. The patient had recently undergone knee surgery and now had severe abdominal pain. Mr Sellu suspected a bowel perforation and plain abdominal radiograph added to his suspicions. A radiologist's view would have been available to him but he arranged CT for the following morning. There was delay in performing the CT and that combined with Mr Sellu's other commitments resulted in delay in laparotomy till later that evening, some 24 hours after Mr Sellu first saw the patient.

Mr Sellu could not produce any evidence that he wished antibiotics to be given meanwhile and the patient died following laparotomy. The jury felt and the judge agreed, that David Sellu's actions (and inactions) constituted a crime. It would seem likely that, based on the facts as related, a civil action in negligence would have gone against him.

Misra, Srivastra, Woodburn

Junior doctors Misra and Srivastra made a serious underestimation of the seriousness of a wound infection and the patient subsequently succumbed to septicaemia.

In the jury's opinion their conduct was so bad as to amount to a crime. They appealed on the grounds that that the nature of the Adomako test was unfair and denied them a fair trial but the appeal was turned down but as junior doctors in a system were they really responsible or was it the system?

Ken Woodburn, a vascular surgeon, gives a moving description of his own experiences of police investigation and subsequent prosecution following the death of a patient with leukaemia after subclavian line insertion. The jury took less than an hour to acquit him.

> "Doctors, with some notable exceptions, do not go to work to harm their patients"

More scrutiny

Where has all this come from?

Forty years ago the mishaps related above would probably have been dismissed as "the doctors did their best" and whilst the immediate, bereaved relatives may have felt that something could have been done better, little more would have happened.

Then came the motor car and we now accept the criminality of death by dangerous driving but in parallel with that much else was changing.

The professions all noticed a loss of deference and we all now (rightly) accept increased scrutiny of what we do. In medicine there is a huge change, not always realistic and some inflated deliberately, in the expectations of patients and their relatives in what can and should be achieved.

In part out of all this has evolved over the years, dramatic improvements in consistency and results of both surgical and medical treatment. The actual measurement of some of the outcomes is problematic and clearly needs more refinement. It will always remain easy, and tempting for the uninformed to measure surgical outcome as living or dead and this is very unsatisfactory, particularly to those practising in the higher risk specialties.

Organisations failing

And how reasonable is all this.?

Doctors, with some notable exceptions, do not go to work to harm their patients. In recent years there has been an increasing focus on system errors but that does not mean that errors cannot be individual. Into which category fall Adomako and Sellu you can decide for yourself.

Ken Woodburn was doing an extra case on an extra list with an unfamiliar team which he had been persuaded to do on a Saturday morning. An airline pilot, with which industry comparison is often made, would not be expected to work under such conditions or without proper preparation, in the interests of passenger safety.

As the direct result of a shortage of beds into which to transfer a neonate, I was once induced to close a persistent arterial duct on a Saturday morning, in another hospital some 50 miles away, with an anaesthetist and theatre staff whom I did not

know, after viewing an investigation on very unfamiliar equipment. (For my trouble my unfamiliar car was clamped for parking in the equally unfamiliar consultants' car park.) Mercifully all went well and mercifully Ken Woodburn's jury recognised, not an individual failure, but a system that had failed and that he was not criminal.

How did Ken Woodburn get there in the first place and where did the manslaughter concept for medical deaths come from?

The police remain relatively inexperienced in the investigation of medical mishap resulting from the possibility of negligence, normally sorted out, more or less satisfactorily, in or prior to a hearing in a civil court. The police are used to dealing in more black and white terms. There is truth or lies. The concept that there is the possibility of more than a single view on management or interpretation of an investigation is alien. At a recent such investigation their feeling was that if there were two declared views of radiological imaging, one was lying.

Little room here for here for thechance of anything but individual responsibility or for the recognition of a systemic failure leading to an adverse outcome. Further, organisations are less than speedy in holding up their hands and saying "it was not poor Dr So-and-so's fault: he or she was doing their best but really we did not/we should have...", opening them to the possibility of corporate manslaughter.

As Ken Woodburn related, he was unsupported by his organisation and although the jury did recognise that the failure was not his, the whole process of investigation and trial, though resulting in acquittal, was a traumatic event for him and his family.

The negligence test

The quality of the test for the existence of the criminal element required for gross negligence manslaughter has received much comment and legal discussion. It is agreed that the civil law concepts of a demonstrable negligence in the presence of a breached duty of care is the starting point. The civil court not infrequently struggles with this and adding a criminal investigation may not be the best route to clarity.

The test is whether the defendant's behaviour was grossly negligent and thus criminal, a question of fact for the individual case which the jury must decide. Where does the threshold lie? How is the concept of system inadequacy putting the defendant in a vulnerable position introduced when the media and hence public reaction, demands and knows "that it must be somebody's fault"? How often have we heard "I know all about system failure but someone has got to be to blame" from those interviewed after a disaster of some sort. Have at least some faith, Mr Woodburn's jury got it sorted out and the police now have much better guidelines for their investigations.

Reckless?

The Lord Chancellor introduced the idea that the concept of recklessness might be helpful in sorting out what is beyond simple negligence. Recklessness is an awareness of the possibility of the particular consequences of an action, or inaction or omission, but continuing regardless. Whilst this concept may be helpful it still remains a matter for the jury to decide whether events go beyond a matter of compensation for the victim and become a public wrong.

And where might all this lead us? The concept is out there that when doctors' actions result in death it might be from a criminal level of negligence. What are the risks to patients of the proposed, reduced (less rigorous?) training of junior doctors? Is the absence of an on call or even resident system for anaesthetists in a private hospital, a risk that could carry an easily foreseeable consequence?

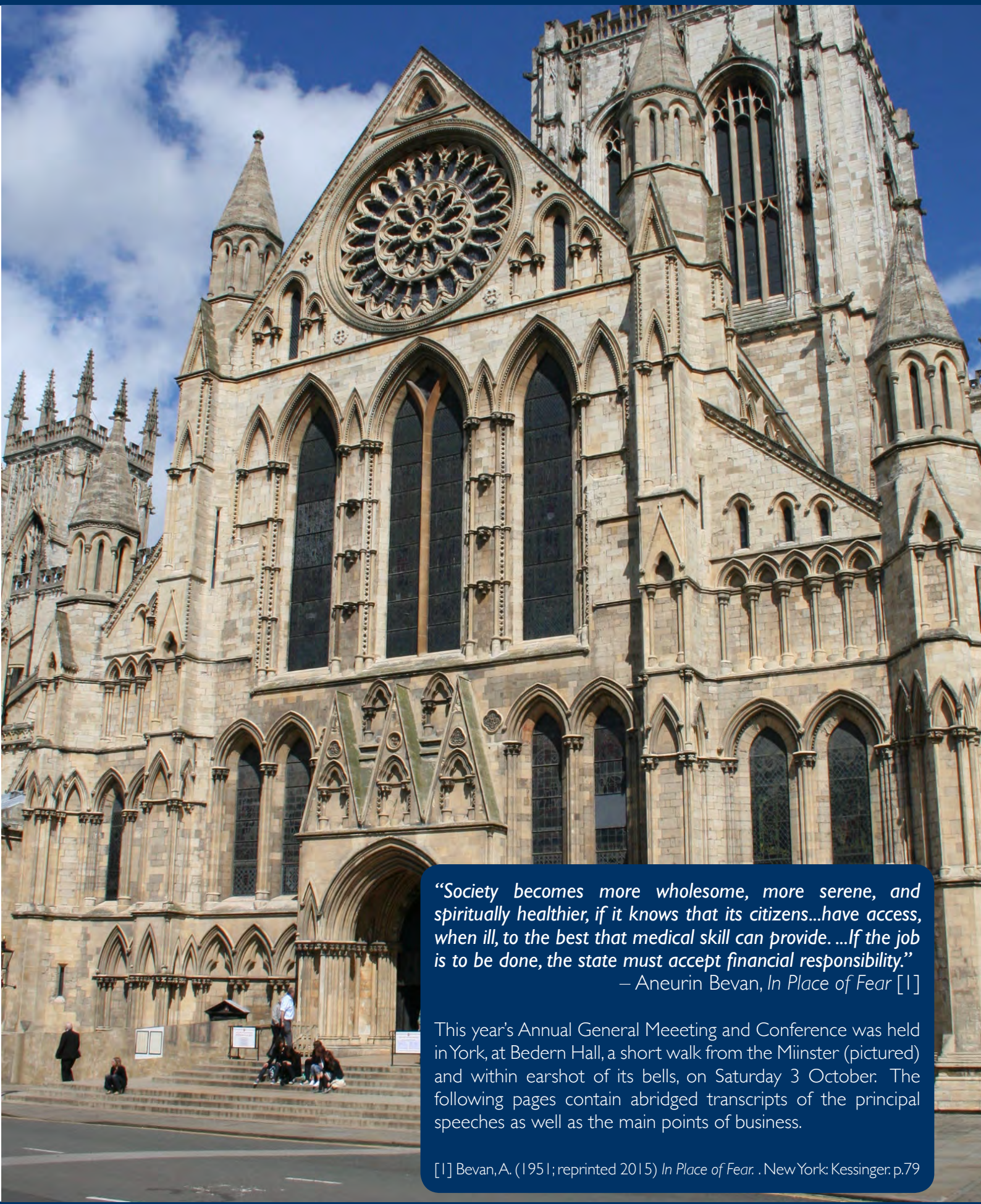
As for Alteplase given following a stroke, how will one demonstrate one was not reckless in giving it (or not giving it) with a known chance of either giving or not giving it, making things worse? How far does one continue to struggle against reduced staffing, pressure to meet targets, knowing that one is running a recognisable and recognised risk? And is one's employer going to jump in and say in your defence that there is a corporate risk in breaching a target? Does that generate a greater or lesser risk to patients than the risk to the patient when working under less than reasonable conditions? The ability to demonstrate that a debate was held (record keeping again) even if it came, retrospectively, to the wrong conclusion must be better than the recklessness of no demonstrable debate.

Sadly it is not preposterous that manslaughter may be considered when a patient dies but sorting out where the blame really lies can be fraught with difficulty.

Labelling an individual as criminal is the end of a career. One can only hope that organisations will be more willing to admit to their shortcomings and further, admit to the great difficulties they encounter when balancing risks against each other, even corporate financial against patient safety.

Roger Franks

AGM and Conference 2015: York



"Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens...have access, when ill, to the best that medical skill can provide. ...If the job is to be done, the state must accept financial responsibility."
– Aneurin Bevan, *In Place of Fear* [1]

This year's Annual General Meeeting and Conference was held in York, at Bedern Hall, a short walk from the Miinster (pictured) and within earshot of its bells, on Saturday 3 October. The following pages contain abridged transcripts of the principal speeches as well as the main points of business.

[1] Bevan, A. (1951; reprinted 2015) *In Place of Fear.* . New York: Kessinger. p.79

AGM Reports

Opening address: Eric Watts, Chair

Eric reported on the very successful launch of the newly renamed Doctors for the NHS in March at Portcullis House in London, which had resulted in a page being devoted to DFNHS in the BMJ and an increasing number of requests for media comments.

He said he had been busy building alliances with other organisations, and also urged those present to start using social media, especially Twitter, as a way of reaching younger members of the profession. The ways of countering attacks on the NHS deserved careful thought, and DNHS members could offer an invaluable perspective based on their years of experience.

Treasurer's report: Peter Trewby, Treasurer

Peter told the meeting that subscriptions yielded approximately £25,000 pa, and that this year the organisation had raised additional funds with an appeal which had covered the costs of setting up the website, launch, marketing, and publicity banners. Alan Taman's appointment as Communications Manager, part time, had resulted in a considerable amount of the work previously undertaken by Peter Fisher in producing the newsletter being taken over by Alan. The introduction of lifetime subscription had resultec in some additional money, but at the expense of slightly reduced year-on-year income. Membership had remained static.

Current assets as of 9 November: £11,421 (interest-bearing account; see Figure 1) plus £3,500 (current account).

Expenditure was currently on the Keep Our NHS Public campaign (£8,000 pa), and £3,000 to the NHS Support Federation. This all meant that at the moment DFNHS was paying out £4-5,000 pa more than its income. This is unsustainable.

Options were to increase subscriptions or to reduce income. The subscription baseline for membership had remained fairly constant, with income from numbers of new members approximately matching memberships ceasing. Peter favoured reducing current outgoings to KONP and the NHS Support Federation as a solution. He put the accounts to the meeting as a correct and full version.

There had been a few resignations over the past year, for various reasons, but none could be said to be because of DFNHS's principles.

The question of holding meetings and events in Scotland as a way of increasing recruitment was raised for consideration by MP and DFNHS member Philippa Whitford. Peter Fisher pointed out that most of the pressing issues affecting the NHS related to England, but he accepted Philippa's point.

After some detailed discussion, the meeting felt that DFNHS should examine the size of its contribution to KONP, especially in light of DFNHS's change of emphasis and its decision to invest substantially in its own continuing campaigning activity. [The EC meeting in November considered this in depth and decided to pay the next instalment of £2,000 due at the end of this year but to review further instalments after that date, probably reducing these to £1,000 quarterly.]

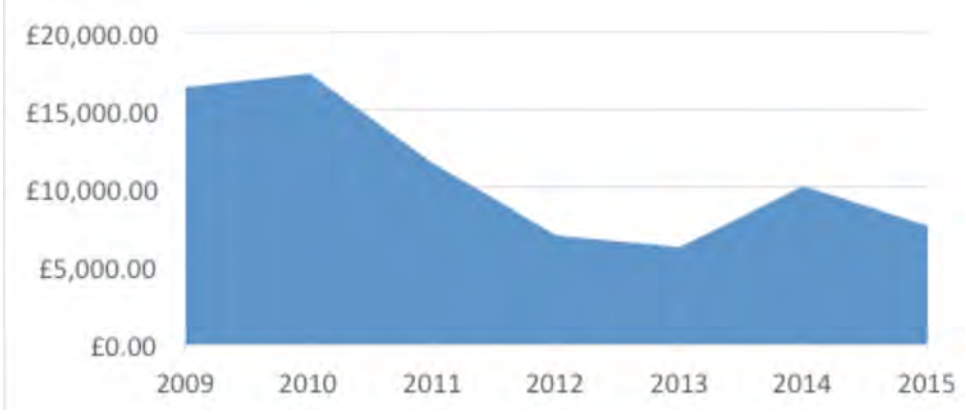


Figure 1 Deposit account balance 2009-15 (excluding one-off appeal donation 2015)

Communication Manager's report: Alan Taman

Alan reported that since the publicity surrounding the launch his principal task had been to change the communications channels and resources to reflect DFNHS's changed emphasis. This included building up and changing the website, developing social media (especially Twitter), some printed resources, and consolidation of DFNHS's e-mail database. Press liaison was ongoing but Alan cautioned that since the election national media had shown less interest in NHS campaigning groups generally. But DFNHS had a unique "selling point" in being a very strong peer group with a powerful voice. The rise of the junior doctors' dispute and the politicisation this was undoubtedly causing amongst doctors in training gave DFNHS a good opportunity to use its more coordinated communications and recruit more members, as well as get

its aims across, especially by focusing on local campaigns. Specific trusts were now being targeted with that in mind.

This new magazine was also an example of the kind of change undertaken since Alan came into post, aiming to be a more "up-market" and outward facing communications resource. This would continue to be developed with more new features over future issues, while remaining loyal to DFNHS's aims and membership.

Alan concluded by saying that communications would continue to be developed and were now in a much stronger position to enable DFNHS to recruit more members and express its aims to a wider audience, based on its unique and powerful nature as "the doctor's voice" amongst NHS campaigning groups.

An interesting point was made during the discussion, that members of the public were generally convinced that the NHS was a "wonderful service" and did not appreciate the nature of the threat facing is. Presenting the dangers in an informed way that was not alarmist was the key. Alan pointed out that this was how propaganda worked, and that there was a credibility problem that groups needed to address through constant explanation and exploitation of particular problems as they emerged, while avoiding needlessly "gloomy" messages about how dire things were getting.

Support motion for the Junior Doctors

The meeting decided to pass a motion in support of the junior doctors:

> **"Doctors for the NHS offer its support to UK junior doctors in undertaking any and all lawful action that seeks to secure a fair and safe contract for junior doctors."**

DFHNS Constitution

Eric Watts reported that the updated constitution had been placed on the group's website as formal notice and put this to the meeting to be adopted. This was accepted.

Recuitment: Peter Fisher, President

Peter reported that each trust in the UK is targeted roughly every 5 years, with each consultant in that trust being sent a letter inviting them to join. Targeted letters were also sent to individuals likely to be sympathetic from comments made the medical press or from word of mouth via existing members.

> "The essence of a satisfactory health service is that the rich and the poor are treated alike"
> *– Anuerin Bevan*

This had yielded a gradual rise in membership historically but a noticeable "trough" in recruitment was apparent since the last election. Since expanding to become DFNHS 200-300 GPs had been contacted and invited to join, with no result to date. Recruitment is vital to continuing success and the group has to come up with new methods of recruitment. Different methods are needed to be developed to attract junior doctors, and the campaign to target trust in special measures was already underway.

The point was repeated that postal methods of recruitment were unlikely to be successful for junior doctors. Social media engagement was likely to be the best way of reaching them. [The website is now being changed to facilitate online joining and be more coordinated with Twitter, to reflect this.]

Alliances with other groups: Eric Watts

Eric outlined the development of a new coordinating organisation, Health Campaigns Together, which would serve to coordinate the actions of the NHS campaigning groups as well as organise several major conferences to be held in the winter of 2016. DFNHS was represented on this group.

Ron Singer's MPU group had also organised a conference to draw like-minded medical professionals and other NHS campaigners together, which Eric would attend.

38 Degrees had also been approached by Eric on a national level but there was some reservation about this group's commitment to the same aims of DFNHS, and its preferred way of engaging with the public on a wide range of issues, not just the NHS. However, the meeting did acknowledge that 38 Degrees had a great deal of strength in organising local groups and that DFNHS could engage with them successfully in this way.

Election of Executive Committee: Eric Watts

Several of the current members were prepared to stand for election, and there were several vacancies (see page 00 for full list of current EC members). David Wrigley was appointed as a new EC member by the meeting.

Keep Our NHS Public report

This was submitted to the meeting. Alan Taman reported that KONP had undertaken a major upgrade and restructuring of its website which had been launched on the day of the meeting (www.keepournhspublic.com)

NHS Support Federation

This was submitted to the meeting. The Federation continued to produce highly useful reports on the NHS.

Major Issues Facing t

General Practice

Where we were: Paul Hobday

The NHS didn't quite make its 65 years; it ended in England on March 2013.

I started as a GP in 1983 and I had the best period, in the eighties, before purchaser-provider splits were brought in. This was after the GP Charter and before the disastrous Ken Clarke's attempts to interfere. It was a good period because we were allowed to get on with the job. The main way of travel was positive and it was gradually improving little by little.

In the 1980s there were 150 good applicants for most jobs. Now we can have none.

In 1948, the BMA was 9:1 against the establishment of the NHS, and produced some bad propaganda. But Bevan pushed the Act through, of course. He wrote this about GPs: "I have a warm spot for the general practitioner despite his tempestuousness. The family doctor is in many ways the most important person in the service. He comes into the most immediate and continuous touch with members of the community. He is also the gateway to all the other branches of the service."

In 1951 he wrote *In Place of Fear* [1] – the chapter on healthcare is amazing. The warnings about how the NHS could potentially be destroyed are as though the right wing have taken them as a blueprint.

Bevan wanted a graduated system of capitation payments to discourage big lists, which obviously would have been a good idea but again the BMA blocked this. For the following 10 years GPs were at war with each other because the more patients they had on their books the more they earned. Basically you could have a big list, do nothing and earn more than somebody who was working quite hard.

Despite a big pay rise in 1952, which kept GPs quiet for a while, the unrest in the early sixties was really beginning to take over. In 1965 all 14,000 GPs submitted their undated resignations the BMA to blackmail Roberts, the Labour Minister for Health. This results in the 1966 Family Doctors' Charter, which revolutionised general practice. It included staff reimbursement at 70%, a group practice allowance to encourage GPs to get together, and other fees. This was encompassed in the "red Book" which was our bible from 1966 to 2004.

But then the rot set in with Ken Clarke's purchaser-provider split. Where did that come from? The right wing have always hated the NHS.

The Tory cabinet in 1957 had a full discussion on turning the NHS into a fully contributory system and this was drawn up in great detail in Whitehall in 1959-60. This was blocked by the Minister for Health, Enoch Powell! Enoch Powell saved the NHS at that point.

But the plots in the background remained. In 1968 the co-founder of the Institute of Economic Affairs, one of Thatcher's heroes, Arthur Seldon, produced *After the NHS* [2] which was about how to introduce an insurance-based system to replace the NHS. The Tories came back into power in 1970. Keith Joseph invited McKinsey to advise on the organisation which was put in place in 1974.

In 1974 Barbara Castle tried to push everything back. The BMA opposed her and when Wilson was replaced by Callaghan, Callaghan sacked her.

By 1982 the Tory cabinet were presented with a Tory think-tank paper, on an insurance-based system, which was seen to be too controversial so it was shelved. But as usual, under a Conservative administration the service was starved of funds. The headlines in the 1980s were all about waiting lists being longer and longer. Thatcher announced a review of the health service. The terms of service of that review were never revealed, but it was influenced by Professor Alan Eindhoven's work describing the internal market, with input form Redwood and Willetts, who are still getting their way.

Blair decided to go along with all this in the end, and produced the death of the NHS by a thousand cuts. First of all, the Fundholding experiment, with the two-tier service, the different types of GP contracts, the out of hours changes in general practice and the splitting off of out of hours so it could be easily privatised, the abolition of boundaries, the walk-in centres which didn't do anything to help continuity of care, and the dismantling of primary healthcare teams. The PCT micro-managing us. Then the 2004 contract came along offering "enhanced services" which were a way of taking work away from us and put them out to tender. Choose and Book: a greater way of getting in the private sector, and making us do generic referrals instead of to specific consultants. Nurse specialists appearing in general practice. And now, tying us into federations on the journey to multi-speciality community providers; and the Health and Social Care Act turning us as GPs into ration givers. All of these were part of the jig-saw, parts of the big picture.

There is one final point that proves this is ideology, and that is the cost of GP practice per patient per year at £72. You can't insure your cat or your car for that. The only reason they are doing this is because of ideology.

he NHS

DOCTORS FOR THE NHS
SERVICE NOT PROFIT

Where we are now: David Wrigley

I think general practice is in a very dark place. I am not one to use such language. I think general practice is on its knees now. I fear for the survival of my profession.

Who would have thought, some years ago, that we would see GP surgeries closing down? It is an absolute travesty.

Primary care in this country was seen as an amazing system. It's all going down the drain. It's absolutely vital we fight for this. One of our biggest concerns is that we will end up with a dentists' model of healthcare. It only takes a group of practices to say "we can't continue like this, we are going to open our lists to private patients" which will attract people to pay for insurance. Just like with dentistry you will have a mixture of provision and then it will be de-funded and we will end up with an over-run primary care service.

I sit on the BMA council, which represents the whole profession, and also the GP Committee. The GP Committee undertook a massive survey. Half the GPs responded. It is quite shocking. One-third of GPs are considering retiring in the next 5 years. One in five GP trainees are considering going abroad; 9 out of 10 GPs have said heavy workload has negatively impacted on the quality of patient care.

These are shocking statistics, all because of what is happening in the NHS. The junior contract is just one part of it. I am firmly behind the juniors. If they beat the juniors, the next will be the nurses, the next will be the other healthcare workers. They are already trying to split the consultants by divide and rule. The juniors deserve our support.

Funding of healthcare is a political choice. The politicians decide. The share of the GDP on healthcare, in 2000 was 6.3% in the UK; in 2013 it was 8.5%. That increase came because of what happened during Tony Blair's time. There were lots of new facilities. Lots of them were under the disastrous PFI arrangements but it did iimprove healthcare.

My patients in 1997 died on the waiting list waiting for heart bypass. In 2000 they were getting them done in 14-16 weeks. Yes, the private sector was used but there was an improvement. But if you look at 8.5% now and compare with other countries, Germany is 11%, Japan 10.2%, France 10.9%, Spain 8.9%, Australia 8.8% - we are right at the bottom of this list.

In 2010 we had the highest ever satisfaction times and the lowest ever waiting times in the NHS. But with the homoeopathic increases in funding since 2010 there has been a decrease in funding after inflation. The GP share of the NHS budget has plummeted. Once over 10%, it is now 6.2%. No wonder primary care is in such a state.

This is a clear de-funding of primary care which I take as a conspiracy. As with the railways in the eighties and nineties we saw a defunded service worsened, it's the same with the NHS: the media roll out the stories and the NHS just gets a worsening reputation and then we will hear "we will have to bring in the private sector, it's the only way to save the NHS".

Only this week I saw more headlines about GPs, "GPs being paid to refer fewer patients". This has been going on for a number of years and has only just been picked up. It's because of the new contract, the decision of the commissioning groups who are in fact an arm of the Department of Health. The funding is inadequate. How do you reduce the spend? Because if the CCGs don't balance their budget they get called to Whitehall and their jobs are on the line. They have to bring in savings. How do you do that? Well, you treat fewer people. In a hospital that means closing wards down. In primary care it means referring fewer patients.

This is often dressed up as "improving quality of care". Data will be collected, GPs will be shown what their referral rates are, and will be told "drop that by 5% and we will give you £20,000'. I think that is completely abhorrent. The potential for destruction of the doctor –patient relationship is immense. Once that is gone, it is gone for ever. That is a very dangerous route to go down.

Lansley and the Tory-led reforms are very clever. They put GPs inside CCGs so GPs get all the responsibility but very little influence. We get all the blame. Because of the disastrous Health and Social Care Act.

Regarding Federations, GPs are sometimes doing that just to save the services they offer because they are under such funding pressures. So some of the federations should not be dismissed out of hand. There ore other ones coming together as limited companies – those we do need to be concerned about.

One solution is to write to your MP and get your friends and family to do so. Write to your local press. People listen if they see a letter about the NHS in their local paper, which have a large readership. Alan Taman will help with any wording (healthjournos@gmail.com). I would also encourage you to look at *NHS For Sale* [3], which I co-authored. It talks about the myths that are undermining our NHS and offers facts to de-bunk them with.

References

[1] Bevan, A. (1952) *In Place of Fear.* (Reprinted 2010. London: Kessinger)
[2] Seldon, A. (1968) *After the NHS.* London: Institute of Economic Affairs.
[3] Davis, J., Lister, J. and Wrigley, D. (2015) *NHS For Sale.* London: Merlin.

New Politics, New Opport

Philippa Whitford, MP for Central Ayrshire, SNP health spokesperson

The NHS is very much what has landed me doing this, as an MP.

I was an active member of the 'Yes Scotland'' group. A ''Better Together'' leaflet caught my eye. This claimed that if we became independent we would no longer have an NHS. That incensed me. The Scottish NHS has existed since 1948; the Highland and Island Medical Service, its predecessor, has existed since 1913. So this is something Scottish people really value. I was looking on in disbelief from 2011 when the coalition government started to say what it was going to do. I realised people in Scotland had not heard of this at all and I felt it was my job to speak out.

At the end of the referendum people started saying I should stand for Westminster. I've been a breast surgeon for over 30 years and a consultant for 19 years; I'd never had the slightest wish to be a politician. A *Women for Independence* rally finally persuaded me, because I realised ''if not me, who?''. The first month in Parliament was a case of ''What have I done, how bad can a by-election be?''.

But now I am the health spokesperson for the SNP. I spent the last week visiting Ethiopia, looking at the health system there. It is impressive. They have health centres like we have, and below that they have what are called ''health posts'', which are staffed by locally employed, young women who work at educating their population in public health.

We finished with a more official meeting. I was utterly shocked to hear that although they think the idea of free treatment at the time of need is marvellous, they plan to encourage the set-up of providers and they will purchase health from them!

I had to leap in and say no, that it is much cheaper to gather in whatever tax you can and if you are meant to deliver that healthcare with public money the cheapest way is just to get on with it and deliver it. It really shocked me that the message that what makes the NHS the NHS is through the purchaser-provider split has reached a place like Addis Ababa.

We are often accused of being the doom-sayer, saying how the NHS is in crisis. I believe you should be completely the opposite. The NHS is amazing. The media are already telling people the NHS is awful. We should not get on board that waggon. What we need to say to people is that the basic principle of a public NHS is the cheapest, most straightforward, highest quality and most egalitarian way to deliver health care.

We must not attack the NHS, destroy how people value it. That is not our message. Our message is that the NHS is incredibly cost effective and worked really well but it is on a trajectory to be broken up.

We must not be on the same platform or we are reinforcing the message which will build up to the point where they peel off the NHS logo and display this wonderful shiny, clever private plan.

Our message has to be about the trajectory that it is on. The privatisation in the English system is only around 7% at the moment but if you look at the bids, more than half of them are going to the private sector, because they have bid teams, corporate lawyers, they will font-load the system, they will loss-lead to win that contract. Then they start changing terms and conditions, they start cutting corners. That is what we need to be saying.

You will find it harder if you are working in a broken up, unintegrated system. To me the biggest loss would be this loss of collaboration. This loss of working together. I think that that is something that we all have a vested interest in.

Our interest in it in Scotland is that we don't get to control our own finances. That is what the referendum was all about: we control our public services, we do not control our own money. If the NHS in England is destroyed or moves to an insurance-based system, that will take almost a third of our funding away in Scotland, which is what we spend on the NHS. That will therefore destroy ours, so we see a vested interest in helping you.

I raised the issue of the NHS Bill with Nicola Sturgeon and her response was to put that in our election campaign. We will be throwing down the gauntlet to see what the new Labour party decides to do about it.

We have talked a lot about what you can do. It's absolutely important that you are who you are: *Doctors for the NHS* carries a lot of weight with the public. Keep Our NHS Public do the local groups, the public involvement, the leafleting. You need to be the voice of authority that says ''we do understand the NHS'' and we can see the road that we're on and that's not the road that want to be on.

But you therefore need to recruit all the people, the GPs, the junior doctors, and if you can fix them up in some way when they are students that is important.

You need to become a much more of a mass movement. Because last year, when my video went viral, what we saw was that the nurses, the porters, the cleaners, the dinner ladies, they were all voting ''yes'' to independence.

Who we didn't convince were the consultants, who were saying we should not rock the boat, and we need to be aware of that, but by word of mouth you are talking of accessing the biggest single employer in the UK, so you can convert staff. I think you should also see the NHS as an organisation that can help itself by taking this road.

Where can I fit in? As the front bench spokesperson I do get to speak in every health debate. I don't need people to

unities

write speeches. But I need facts. The principles. These are things I can use in parliamentary questions, I can use them in debates and can get them aired.

In Scotland our population now with Parliament Live TV, they put it on Twitter,. What this organisation needs to be doing is to try to get that happening around the NHS. We know it is the thing that is most values by everyone in Britain, in the UK. We need to get them all talking about it. No attacking it, not moaning about it, but realising it's exactly as we said before, the reason you get good is through good people. We have to support those people and we have to keep it public.

Some of what the Conservatives are talking about is not targeted at people who are ill but so that they can create this "'Tesco's"; they keep going on about Tesco's: you can pop in 24/7 and get your shopping. Well you're not getting a fish-monger, the bakery is shut and the butcher is shut. on a Sunday. So even they do not provide everything 24/7.

We need to be clear that is your message, what is your voice? I think you have to get the entire profession speaking that message among themselves, among staff and to the public. Because that is what we need to do. We need to get such a welling up of a wish to protect the NHS that it is something that they have to listen to. All of us can contribute to that.

If I can contribute in any way by just getting those going out to my Twitter followers or into the Chamber or into *Hansard* then obviously I would be happy to do that. I think we have a huge job of work to do and I am really glad we have changed how we see ourselves and can take that forward.

Follow Phillipa onTwitter:
@Dr_PhilippaW

Devo-Manc

Report by Eric Watts

A bravura presentation from JS Bamrah, Medical Director of the Mental Health and Social Care Trust in Manchester and Chair of the NW Region of the BMA, who described his involvement in the scheme as "someone who would rather be in the tent looking out than the reverse."

He commented there was no public vote for the scheme and that many are against it, partly because of the long secret negotiations carried out between Osborne and Bernstein of the Manchester City Council described in Simon Jenkins article in the *Guardian* [1].

Key points are that it will:

- Continue to deliver the NHS Constitution and Mandate requirements and expectations.
- Commit to the production, during 2015-16, of a comprehensive Greater Manchester (GM) Strategic Sustainability Plan for health and social care.
- Seek to play a leading role in designing and delivering innovative new models of care as set out in the FYFV. It will use the opportunities resulting from its GM-widescale and integration to create ground-breaking innovation in areas of mutual GM/NHSE strategic focus to be agreed, and to be an exemplar for the national whole system efficiency initiative.
- Ensure clear accountability, exemplary governance and excellent value for money in relation to the health funds delegated or devolved to it.

He reported that the publicity has stated that the underlying principles are GM will still remain part of the National Health Service and social care system, uphold the standards set out in national guidance and will continue to meet statutory requirements and duties, including those of the NHS Constitution and Mandate and those that underpin the delivery of social care and public health services.

The planned timetable is April 2016: full devolution of agreed budgets, with preferred governance arrangements and underpinning GM and locality S75 agreements in place.

The scope will include:

- Acute care (including specialised services).
- Primary care (including management of GP contracts), who will continue with their independent contractor status.
- Community services.
- Mental health services.
- Social care.
- Public health.
- Health education.
- Research and development.

This much was easy to follow but I was not alone in thinking that the vision of the benefits will be hard to realise, the planners have said that their plans, involving closures, cutting numbers of health and social work staff will result in improvements.

Gasps of incredulity were followed by ribald laughter as the predictions were read out:

"By 2020 there will be:

- 4,000 fewer children and 60,000 fewer adults with chronic, long term conditions;.
- 6,000 fewer people will have cancer.
- There will be a 10% reduction in visits for urgent care.
- Around 18,000 children will be better supported by local services to live in stable, caring homes.
- Nearly 70,000 extra people with chronic conditions will be provided

with community help.

- Reduction of elective hospital services by 15%.
- 25,000 people with severe and long-term mental illness will benefit from proactive community care.
- Involvement with urgent services will be reduced by 30%."

This, the advocates suggest, will be achieved in spite of the budgets being reduced so that they cannot deal with the consequences of many severely deprived areas with the highest UK suicide rate outside Glasgow.

Not only are the needy set to suffer but at least one centre of excellence is to be excluded from the grand plan.

The consultants at Withenshawe – a leading centre of cardiothoracic research – are so inflamed they are on course to launch a Judicial Review, which could stop the whole process.

He concluded with an expectation that there would be steady flow of embarrassing headlines as the story unveils.

Reference

[1] Jenkins, S. (2015) 'The secret negotiations to restore Manchester to greatnesss'. *Guardian*, 12 Feb [onlline] available at: http://www.theguardian.com/uk-news/2015/feb/12/secret-negotiations-restore-manchester-greatness

FYFV: The Devil in Disguise

Anna Athow

The *Five Year Forward View* is a plan to privatise the provision and commissioning of clinical services in the NHS within 5 years. It proposes a gigantic reorganisation of the provision of clinical services.

The name being given to this reorganisation is "transformation". There are many references throughout the document to a shift of care outside hospitals. A number of new models of care are listed.

What it does not say is as important as what it does say. It says "outdated models of delivery have to go".

What this means is that District General Hospitals have to go and GP surgeries have to go. Another key point is a "modern work force". By deduction there is to be a new workforce, and we have already started to see the decision to smash current national contracts. Implantation is about commissioner dictatorship by various means, which is top down. £22 billion of cuts in the next 5 years. They want £8 billion to carry out the "double whammy" of a transformation and push it through.

The result will be a cheapening of provision by bringing in the new care models and the new work force, pay freezes, new staff contracts, and selling off NHS property.

Stevens has said that he hoped they would sell £7.5 billion on NHS assets. The aim of all this is "productive investment". What is "productive investment"? It is profits for private companies. There is no mention of privatisation – but then they can't do that – but that is what productive investment means. They think that on the back of these changes there will be scope for profits to private companies.

This is aimed at an American-style system based on health insurance.

They want skill-mix change. Doctor-substitutes doing doctors' work, etc. They want completely new models of staffing: many hospitals they do not want to have surgeons at all. They want "generalists" and what they call "hospitalists". They want to end the current national contracts of doctors for "service redesign", and Agenda for Change for other staff. They want to shorten medical training. They want an army of volunteers which is largely about bringing in volunteers to do skilled work on the wards.

They want "7-day services". This is important. They want to set up accountable care organisations, which is modelled on US healthcare. In essence this is a type of health maintenance organisation.

These will be big: 30-50,000 patients each or more. They will be doing primary care, mental health care, social care, preventative care, out of hours care, public health care, and they want the capitated funding for all these services. The Vanguard services are essentially these ACOs, for which bids have to be submitted. In my view they are being prepared for private providers.

Urgent and acute care networks: they are proposing that half of our type 1 A&Es go. This means people will have to travel an awful long way to get acute care.

Foundation trusts are now being aligned into hospital chains, which are clearly modelled on US and German-type private hospital chains. These could be satellite services or placed with a multi-speciality community provider (MSCP) but they would not be run by consultant-led teams but by "hospitalists" and the people in the MSCPs would run them. Dumbed-down DGHs.

Specialised care: they want, for example, cancer care and orthopaedic care to be called "specialised care". I see no reason for stripping these out of DGHs and putting them into huge private contractors, but this is what they want.

The demand for Saturday services is the government's way of pretending they

care about public services, but in reality it is a way of changing the workforce. They cannot achieve a change to the working pattern unless they change the working terms and conditions, the doctors' contracts.

Jeremy Hunt has claimed "around 6,000 people lose their lives every year because we do not have a proper 7 day service in hospitals." He is trying to pretend that this so-called excess deaths at weekends is something to do with the consultant contract, whereas as emergency cover is not affected – this is provided 24/7 and always have been.

This is being done because commercial companies want to take over the running of the NHS. They can't make money unless they get people to do Saturday, Sunday and evenings doing electives, outpatients lists and endoscopy lists so they can have a big throughout of elective cases.

Also, the new "super-hospitals" must cover acute care, and they need a massive amount of elective care to cover this. What they need to do this is sweated labour: medical staff in there evenings, Saturdays and Sundays doing the elective work.

The main feature of the junior doctors contract is the increase in plain time working form 60 to 90 hours a week: 7 am to 10 pm Monday to Saturday. That is what has to change: they want cheap labour in the evenings, Saturdays and Sundays from junior doctors. They want to get rid of the compensation juinor doctors used to get for unsocial hours working, banding. They also have safeguards to make sure they weren't working excessive hours, but this removes the monitoring of that.

Consultants contract: same plain time working changes as the junior doctors. Imposition of elective work at evenings and weekends. Private companies need this otherwise they can't get the new models in.

This government is also pushing through anti-trade union legislation which target the NHS workforce.

All these things are to replace our NHS. But we do have a lot of our NHS left.

Devolution: The Hidden Agenda for Public-Service Destruction

Deborah Harrington, National Health Action Party

Everybody seems to think this is absolutely the thing to do – much of the agreement is cross-party. Whlle I absolutely agree with the principles of democratic decision making being devolved to the lowest level possible, I can see no evidence that this is what is entailed in the current discussions.

The rhetoric of devolution fails to match the reality. Also, government commitments today can be undone by commitments tomorrow, with threatening consequences.

The immediate context to devolution includes unprecedented cuts to public funding of services and social support, escalating housing prices, massive changes to the NHS, and a fundamental change in the ethos driving public sector provision away from the basis of our combined service solidarity towards the management of public expectations within a framework of private provision. The latter is one of the greatest risks for devolution, if you believe as I do that public service is best when it stays public in ownership, delivery, funding and accountability.

The scale of the funding cuts has a direct impact on devolution. Since 2010 local councils have suffered an almost 40% budget reduction in real terms. Like the NHS, they have had to make efficiency savings, by cutting staff and selling property, to make good the gaps but many services have been severely depleted. The effect this might have on the NHS is clearly the issue of paramount importance here but in the broader context those elements that are referred to as the social determinants of health which lie in the remit of the local authority which cast light on how the NHS might faire under devolution. I would like to illustrate how the existing structures of local government might impact on the transfer of responsibilities and to look at a case study to highlight the gap between the rhetoric and the reality of localism.

Devolution is about the devolution of a budget from central government to the local authority. It happened in 2012. The government legislated for local authority housing to be self-financing for the first time. This was an absolute revolution in moving money out of central government down to local government, who would then be able to use the money for what they wanted. This sounds like perfect devolution. But this year a second legislative round gave a shock to local housing authority managers. This was two fold. First, the government made an "intervention" unprecedented on rent levels. Tenants who earned more than £40,000 combined household income would have to pay affordable rents rather than council rents. Affordable rents are set at 80% of market rent. All the other tenants would have a rent reduction of 1% per year for the next 4 years with no allowance for inflation – a huge decrease in total rents collected.

The second part was even more shocking. A percentage of council properties deemed to be of high value must be sold off as soon as they are vacated. It has been estimated that every single council property in Westminster, Kensington & Chelsea, Wandsworth and the riverside area of Southwark will have to be sold. The viability of the housing stock will collapse. The income from housing stock will not cover the necessary outgoings.

This has reverberations echo through

everything: you are told you are going to be given the money to do everything, then the money is taken away. Housing is, as Bevan knew and every health professional in the country knows, a major social determinant of health. Being able to pay for your home with or without help is an important security. The combination of social security and social housing changes is primarily having a negative impact on people who are not well enough mentally or physically to sustain of obtain employment. This is particularly marked in those with mental health needs, who are also struggling to access support as our NHS services collapse. With funding levels as they are, we have been able to employ another housing officer to support these people: housing officers are having to give support to those who are mentally ill and vulnerable. This is in jeopardy. This is the situation into which it is proposed to merge major responsibilities including health under the devolution funds.

The NHS - and yourselves – are aware of the extent of the disparity between promise and practice of legalisation. Public health budgets are facing a £200 million budget cut this month. CCGs have failed utterly to be accountable or transparent. The NHS was created because local authority provision was not capable of coping with the dreadful health inequalities across the country and there was no universal or comprehensive health care.

Devolution decisions are being rushed into without considering whether regional differences can be properly accounted for under such a system. NHS England is talking of withholding budgets if specific criteria are not met. Local councils may feel they know their constituency better than any national government but will they have the power to argue for budget increases to match the fluctuating demographics that a national service can currently take account of? This is set not only against a background of cuts but also a growth agenda which relies on local authorities being able to generate extra business income. There is very little clarity about how demographics themselves will be mapped. The localising of budgets and provision, especially in our critically under-funded local authorities. Risks perpetuating those conditions of pre-1948 inequality. Rather than producing good, appropriate local provision responsive to real need. Those people from my local area who will shortly be displaced from their council homes will join the 50,000 already scattered across the country by the social cleansing programmes that put property values before human need and view being supported by social security as an innate moral failure.

What is to me the final poison that infects the body of local politics is privatisation. Local authorities are already well-established outsourcers. The new local authority model will be a fully commissioning council, a council that has virtually no employees, its own version of a CCG. Local authorities have already privatised many if not all their care homes. Charges are in place, means tested for social care. Merging these projects within the means –tested and privatised remit for local authorities opens the clear pathway for charging for health services. CCGs have a responsibility for making further efficiency savings form next year. There will be a reduced core menu of NHS services being funded and anything outside that core is a target to be a mean-testable service. As local authority departments find themselves providing core for services in crisis and for which they are not properly trained, the dangers lie in limiting the national character of the NHS - that we will end up providing a service of last resort for the poorest, losing the universal can comprehensive service completely and to grasp charging as the only recourse and last resort.

I hope you will agree with me, that no matter what the rhetoric and promise of devolution, it's reality and practice is to bring to an end the NHS.

Paul Noone Me
Rachael Maskel

Rachael's background

20 years as an NHS physiotherapist, trade union official, Labour MP since May 2015 with over a 6,000 majority , supporter of Andy Burnham in the Labour leadership campaign, recent Health Select Committee member, local campaigner for protection of York mental health services and current shadow defence spokesperson under Maria Eagle.

Power, its use and abuse

Rachael began her lecture with a clear message of intent: that she planned to persuade us, a key group of health professionals, that we have the knowledge, the collective power, the public support and a duty of care to take on the politicians such that their political objectives are overturned and replaced by vital clinical outcomes for an NHS under threat.

She warned how it is so easy for individuals, acting alone, to lapse into a state of accepting and conforming to agendas set by politicians and others who take control of communities, as a survival mechanism for coping with energy sapping feelings of powerlessness, hopelessness and despair.

As an illustration of this process and as a message of how change can be achieved she described what happened in the Chicago slums in the 1940s and 1950s under the inspiring influence of a Russian-Jewish immigrant Saul Aliskey, whose book *Rules for Radicals*. written just before his death in 1972 is according to Rachael a" must" to understand how power transfer is at the heart of political change. Saul took under his wing a group of African Americans living a life of serfdom and mafia exploitation and helped them form community groups to begin to challenge their exploiters.

morial Lecture 2015 : Who Holds The Power?

ll, MP for York Central (report by Geoffrey Mitchell)

He taught them about power and how those controlling their community only had their power because of a too ready acceptance of and submission to it, of how it was possible to remove power by refusing to accept it, not so much by individual action but by using collective power built on trust and confidence within the group.

Turning to politics and specifically the politics of the NHS Rachael explained that holding power and collectivising power is the basic principle of politics and the basis on which political movements, trade unions and campaign groups are organised.

The hidden agenda

With the current NHS crisis ,the first task is to define who is setting the agenda and then to uncover how they are achieving it. Rachael has a clear vision of what is happening:.

Jeremy Hunt, Health Secretary, has a covert agenda of privatisation and is ruthlessly exploiting patient safety as his repeated manipulating message to the public, starting with the first message to be learned from the mid-staffs enquiry, namely that the labour Party cannot be trusted with the NHS as the problem arose under their watch.

He has calculated that he can expect the public to cling to the memories of the reported deficiencies in patient care with safety as a central issue such that no one can argue against whatever measures are being proposed around patient safety, whether they be changes to clinical service or medical contract. Only two months ago he was noted to make 12 references to Mid-staffs with the Health Select Committee.

The charade of prioritising patient safety has been all too evident locally in York with Bootham Park mental hospital a grade I listed building with a long distinguished history of provision of high quality mental health care inspected and declared unsafe and requiring structural modifications to admission areas in particular, last year by CQC, who found on a recent revisit that the mandated maintainance work and other safety changes had not been carried out and ordered closure of the hospital. The Vale of York CCG has since then transferred patients, some as far away as Middlesborough under completely new clinical teams with major impact on patients rehabilitation programmes and stress and inconvenience to relatives and carers.

The lack of coordinated responsibility by the different bodies working within the complex framework of the H&Social Care Act lies at the root of the closure with patient care and safety hardly a priority.

In current government-speak, pay restraint measures are justified as a means of protecting jobs, and job losses have impact upon patient safety, strikes are reckless and accepting that staff are needed to work at weekends necessitates making changes to terms and conditions -----these are just some of the devious arguments being used to achieve the covert goal of privatisation ,with outsourcing and running down services through mergers, closures, service reorganisation being justified in public on safety grounds in preparation for a message to the public that the NHS is failing and that the solution to provision of safe health care rests with Virgin care or care UK for example.

Collective power

Rachael argued that as Key healthcare professionals we have to use Jeremy Hunt's case for patient safety against him utilising an evidence base and a vision to challenge these deceptions and an identification of and close working with allies whether they be political parties, trade unions, campaign groups, communities, academics, journalists, writers ,media personalities We have to take on an educational role with the collective as Saul Aliskey did in Chicago with Doctors having to realise that they cannot afford to go it alone, that they have to use parliamentary opportunities to ask questions, to influence local MPs and attend meetings with Ministers.

We must hold on to the substantial power we have, not be to complicit, challenge head-on funding shortages, shaving of budgets, downgrading of staff and be prepared to refuse to accept unreasonable unpaid overtime. We should recognise that in our collective objective it is better be" for" something rather than against --"vote yes" is stronger than "vote No". Agreeing the issue is the hardest thing but essential .

Collective action should be smart action. Short of strike behaviour is sometimes better than actual strike action. Rachael gave as illustration how a dispute over night time provision of emergency pathology tests in North Wales was resolved by an insistence that the lab manager would require to be telephoned over every emergency request. The lab manager soon settled the dispute!

Rachael concluded:

"We have done the marches, the protests, the strikes, but the NHS is rapidly imploding. You have a duty of care to your patients You will put patient safety above every consideration. You have the understanding to hold your power and not conform or give in. You have the transactional agreement to share your power. You have the evidence, the knowledge, the public support, the1.4m working in the NHS. Jeremy Hunt doesn't have a clue what he is talking about. Who's National Health Service is it? Organise – and you will win!"

The Next Few Years – What Should Lie Ahead for Mental Health Services?

The important themes which will affect mental health in the next 5 years are those affecting other medical services: marketisation, privatisation and fragmentation of care.

Section 75 of the Health and Social Care Act requires commissioners to put all clinical services out to tender unless the NHS is the only possible provider. Private contractors win these tenders in competition with doctors, many of whom have never seen a notice of tender. Care UK, Virgin Care and others cherry-pick easy and profitable services such as diagnostics, routine elective surgery and simple treatments – leaving behind A&E and anything that is unpredictably expensive.

In July 2015 the NHS Support Federation reported that in the previous year the private sector has won £3.5 billion of NHS clinical contracts. This total is five times the amount they won in the first year of the NHS changes, from April 2013-14. Private companies have consistently won the majority of tendered NHS contracts. Unless Caroline Lucas's NHS Bill is passed by parliament, there really is nothing positive left to say about the NHS's future.

What has happened to mental health services? This is about three problems and their solutions:

1. Management interference in clinical practice.
2. Number of psychiatric beds.
3. Splitting up of integrated multidisciplinary teams.

1. Management

Mental health services were subjected to management interference in medical, nursing and social work practice long before other specialities. The Care Programme Approach (CPA) was introduced in England in 1991, having been imported from the USA.

In the USA the closure of state psychiatric hospitals was accompanied by the appointment of largely untrained individuals called case managers who were given a budget to place individuals in the community.

Because of their lack of training, elaborate paperwork was required to check on what they were doing and unfortunately this process was exported to the UK. Initially it was intended for use with forensic psychiatric services, but by 1996 it had become a key component of the entire mental health system in England.

With each scandal in the community that occurred, the paperwork, particularly risk assessments, became more elaborate. Thus where I worked there was a listing of risk factors for suicide, homicide and self-neglect covering over two pages of yes/no answers which took far too long to complete, which was largely incomprehensible to anyone other than the person who filled in the form, and which didn't give sufficient information about any of the numerous items on the list.

The laboriously compiled CPA documentation was hardly ever read by anyone. Every item has to be completed for every patient. It was as though if one was shooting an arrow at a target, one would shoot off arrows in all directions, just to be on the safe side. Community psychiatric nurses spend a substantial part of each working day at computer screens filling in forms of little use and of unproven reliability and validity. This is at the expense of face-to-face contact with their patients.

Despite research showing that risk assessments make no useful contribution towards predicting untoward events, when an adverse event such as a suicide does occur, the first response of management is to ask to see the risk assessment.

Of course what counts is the quality of the service, which is subject to repeated cuts.

We need is to get non-professional micro-management out of our hair, we need a lightening up of current documentation requirements and we need a restoration of reliance on clinical skill and professional judgement. Arrows should be shot directly at the target and not all over

the place, supposedly to be on the safe side.

2. Psychiatric bed numbers

In the 1970s there were studies from Sydney in Australia, Wisconsin in the USA and elsewhere showing that community interventions could reduce the number of admissions to psychiatric hospital beds. In response there was a reduction in bed numbers in the UK, but the reduction was pursued over decades with untoward zeal by hospital managers to a degree way beyond anything relevant to the research literature. The fewer the number of psychiatric beds, the lower the cost and the more Brownie points managers earned. Beds became a four letter word not to be mentioned in polite company.

The OECD figures for psychiatric beds per 100,000 population for the year 2011 are as follows: Belgium 180, Netherlands 170, Norway 130, Germany 120, France 90, the OECD average (which includes countries such as the Slovenia, Poland, Estonia and Hungary) 70 and the United Kingdom 50.

Where I worked at the Bethlem Royal Hospital, bed numbers were cut to three admission wards serving a population of 330,000. We had bed occupancies up to 120%, patients were asked to move from their beds late at night and there were considerable problems in finding beds for emergency admissions.

Unbelievably in that context the managers put the case for closing one of the three wards. Some of the money saved by closing the ward was to fund the creation of a community psychotherapeutic resource which was supposed to prevent admissions, but which had no prospect of doing this. The closure went ahead with predictable results: a worsening of the problems and a greatly increased use of private sector beds mutiplying the cost of these admissions.

The situation is worse for child and adolescent psychiatry: some counties and boroughs have no beds at all for this group. The *Five Year Forward View* speaks of investment in new beds for young people with the most intensive needs in order to prevent their being admitted far away from where they live or onto adult wards, or what is not mentioned, their ending up in police cells. But the Five Year Forward View does not indicate from where the funding for these beds will come.

> "With each scandal in the community that occurred, the paperwork became more elaborate"

This shortage of psychiatric beds mirrors the shortage of all-speciality hospital beds, so that in 2012 England had 51% of the EU average of 27 countries. France and Germany had far more than the EU average.

Despite the financial shortfall for clinical services, annual NHS spending on management consultants doubled from £313m to £640m between 2010 and 2014 according to a Freedom of Information request by David Oliver.

3. Teams split up

Previously there had been integration of community and inpatient teams and so a patient seen in the community who required admission would be looked after on an inpatient ward and followed up after discharge by the same psychiatric team. No more. No one knows the NHS source of the idea to fragment the community and inpatient services. I suspect the plan was to break up the whole into packages which could be sold off.

The split of the integrated service was proposed and speedily implemented. Obviously it is disadvantageous for a person in a disturbed mental state not to have the same personnel involved in their in-patient care. Not only is it a question of totally different faces on admission, but the detailed psychiatric history given to the community clinician has to be relayed, or repeated, to the inpatient clinician. In the real world, a lot of important information is lost. After discharge it takes a week or two, usually two, for a discharge summary to be produced, so that following discharge patients arrive in a fragile state at the outpatient service where the clinician is largely in the dark as to what happened on the ward.

The suicide rate for any given period of time is highest immediately following a psychiatric inpatient discharge, so this is entirely the wrong time to have discontinuity of care. The re-integration of the two services would be a goal for the future.

Morris Bernadt

[This article is based on a talk given by the author at a Keep Our NHS Public conference in July 2015 at Queen Mary University of London, '*The next few years – key campaigning themes*'.]

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