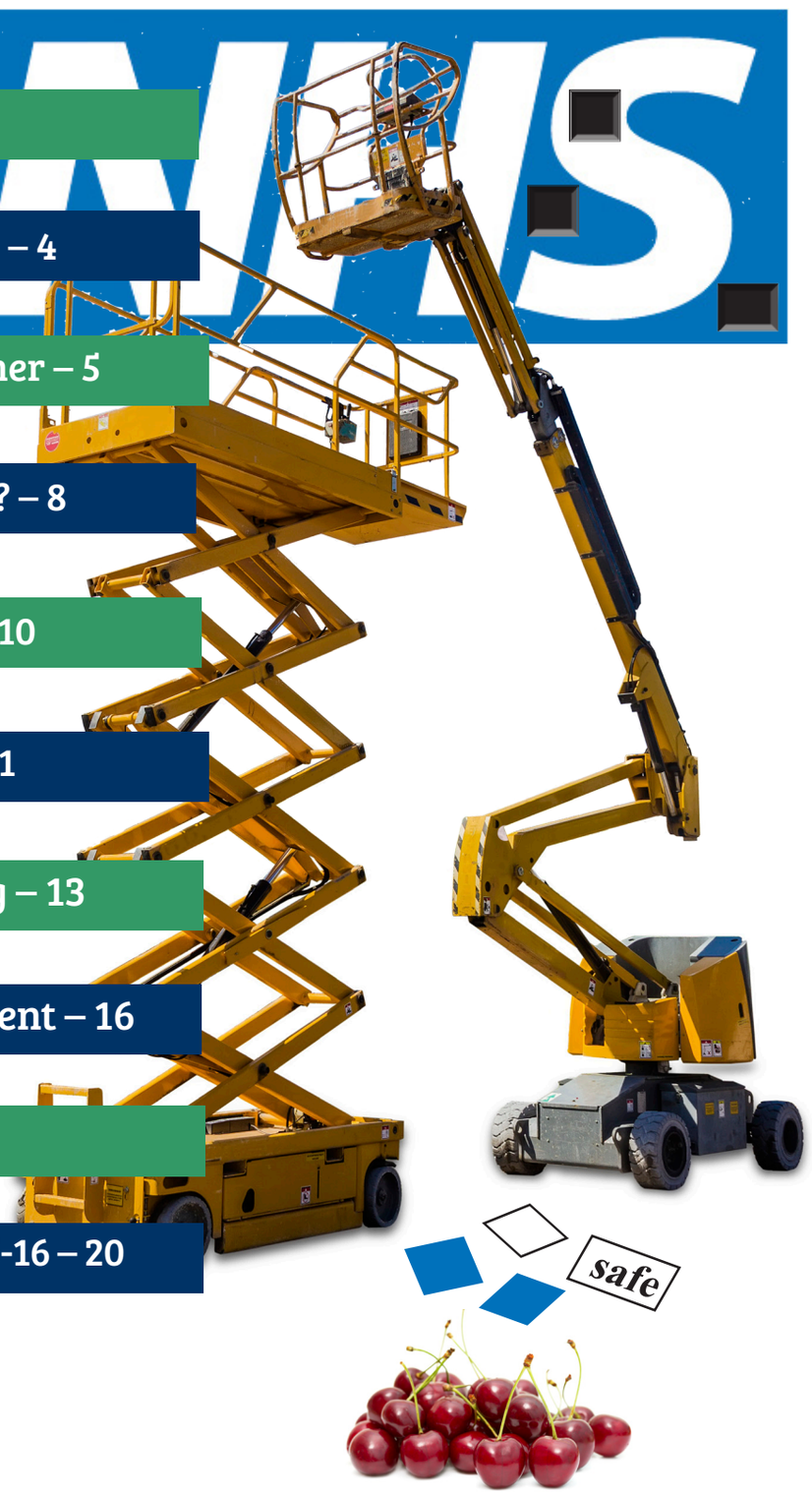
DOCTORS FOR THE NHS
SERVICE NOT PROFIT

NEWSLETTER

"The NHS is [redacted] in my hands"



MARCH 2016

Editorials

"Once more unto the breach, dear friends, once more"

The famous words of prince Hal [*Henry V*, act 3, scene 1] encouraging his troops to battle are fitting today, particularly the repetition of "once more" as we have been here many times over the last 40 years. Our battle to restore the NHS to its founding principles. The breach Hal refers to is a physical one – the gap in the wall of the city of Harfleur, which the English army held under siege. The breach we must attack is the weakness and superficial nature of the arguments against our proudest national institution.

The facts speak for themselves, the NHS has consistently performed well in international comparisons and it benefitted from the increased funding at the start of the century but the services and the essential social services, on which many depend, are being cut with predictable results.

We do not fight alone and much of this issue describes work with other groups united in a common purpose, hearing our colleagues' determination brings back to mind some more lines from that speech:

'In peace there's nothing so becomes a man
As modest stillness and humility:
But when the blast of war blows in our ears,
Then imitate the action of the tiger;
Stiffen the sinews, summon up the blood,
Disguise fair nature with hard-favour'd rage.'

DFNHS as a body of professionals are naturally committed to continuous improvement and are keen to use our knowledge gained from working with the hard realities to evaluate new plans and interpret evidence of effectiveness. As such we would normally opt for fair nature than "hard-favour'd rage" but the atmosphere is becoming increasingly confrontational.

As we enter our second year we see our purpose more clearly defined. Originally we set out to affirm the benefits of the NHS but in the last 12 months we have seen increasing undermining of the very pillars of strength that have made it successful, in particular the planning processes and the resolve of the workforce.

Co-ordinated comprehensive care has been taken for granted as a prerequisite for successful healthcare delivery but the last year has shown several examples of schemes which have deliberately broken with standard NHS procedures with disastrous consequences, as described in this issue. The workforce has never been angrier, the junior doctors' dispute has radicalised the most unlikely of people to demonstrate, with widespread support from the workforce and public.

We, DFNHS, are neither a political party nor a union; we are a body of doctors who believe our experience has much value in determining how health should be provided.

That said it is hard to find anything to support in the government's plans and the more astute political observers have been quick to point this out.

It is becoming clearer that the threats to the NHS are ideological but disguised in the terms of everyday economics. The well-peddled myth that the NHS is too expensive draws attention away from the simple truth that other systems are more costly to run. The attacks are ideological because it is the government's plan to shrink the state and the NHS is the very embodiment of the state at work.

The recent series of articles in the *Guardian* has provided more detail, both on the facts behind the inadequate funding and on the effects on the workforce. The much flaunted "Extra £ 8 Billion" sounds good but amounts to only a 0.8% rise in funding compared with the 2010 level, compared with a rise in demand of between 4 and 5%. This makes a good case for expanding the role of the state in providing more funds and in reversing the cuts in social care which have led to increasing hospital admissions and difficulty in discharging patients home.

The professional and public anger that has been generated is being channelled into many organisations and I have met with their representatives at the Health Campaigns Together meeting, reported in this issue.

Since our last issue we have seen the NHS celebrated in the warm glow of the NHS Choir number one single, "A bridge over you" but the cold blast of January brought with it the first doctors' strike in 40 years and a special meeting of GPs of the LMC with a call for mass resignations. Although that call was not passed it shows the high level of anger amongst GPs.

This year so far has seen the first meeting of Health Campaigns Together and March 11th will see the NHS Bill given its second reading in the House of Commons. I shall be there to add my support. This bill defines the NHS restored to its defining principles, a clear statement of the alternative to the current woes, and is the light at the end of the tunnel, which we all need.

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The contract battle

Victories, defeats and tactics

The NHS Support Federation, one of our "sister organisations", chonicles contracts going to the private sector (even devoting an entirely new site to the process: http://www.nhsforsale.info). In January, they reported that £16 billion of NHS clinical contracts have been awarded through the market since April 2013 (411 contracts).

This could lead one to ask if we are like Canute facing the rising tide. On a more positive note we should learn from our successes as local actions have prevented many ill-considered schemes from being implemented.

Given that the contracts are at least theoretically negotiated by local CCGs and would reflect local political allegiances it is notable that the Conservative stronghold of Chichester rejected a BUPA takeover of the MSK services.

38 Degrees have proudly announced that children's community health services and the inpatient adolescent mental health unit in Bristol have, for now, been saved from privatisation.

This is a massive victory both for NHS services in Bristol and the rest of the country.

It shows what can be done when service users, staff, members of the public and councillors and MPs work together to hold the public bodies who make decisions about our NHS to account and let them know what we want for our health services.

Those who are battle weary can put "success" into the search box of the 38 Degrees website (https://home.38degrees.org.uk) and up will pop many more examples.

One much awaited announcement comes from the Cancer not for Profit team from North Staffs (see also pages 11-12), quoting from the *Stoke Sentinel* on 2nd February:

"The move to sell-off £687million of NHS cancer services in Staffordshire has been put on hold. The tender – opposed by a 70,000-name petition – was halted following the collapse of similar procurement of £800million of elderly care in Cambridgeshire after 8 months because it was financially unsustainable.

"The 10-year cancer contract should have been awarded by December.

"But health bosses last night confirmed no announcement will be made until a review of what went wrong in Cambridgeshire had been completed."

There is a pattern emerging of successful campaigns; some causes will get a good public response. Closures or threats of closure of hospitals will stir people into action but piecemeal removal of services are harder to identify and local activists will need to use the system, eg representations to the CCG or the County Council Health Overview and Scrutiny Committees to make their points.

One interesting spin-off from picketing with the junior doctors was reported by Pam Zinkin who met many people on the picket line who asked what the strike was about. She arranged for the juniors to go along to a pensioners meeting to explain their case and gained overwhelming support. Perhaps we all have pensioners groups nearby, waiting to be radicalised?

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Royal dissent?

One of the principal supporters of the call to hold a Royal Commission to look into the future of the NHS, Green MP Caroline Lucas, withdrew her support for the idea publicly recently. In a statement issued to defend her actions, Caroline said:

"I very much hoped that supporting the idea of an independent, cross-party commission on the future of our health and social care service, could help ensure the vital arguments for keeping our NHS public were not further side-lined in Westminster. I have always favoured getting people from all sides into a room.

"But there are clear red lines – or there should be. Having listened to the recent parliamentary debate on whether a commission should go ahead, I have concluded that too many lines could be crossed.

"I have therefore withdrawn my support for the NHS Commission Bill.

"Without a fundamental commitment from all involved, to the NHS as a taxpayer funded, publicly provided, publicly accountable, universal, comprehensive, equitable and free at the point of use health care system for all, a Commission runs a serious risk of becoming a vehicle for privateers, to further profit from the fracturing of the NHS.

"It's time to abolish the false distinction between nursing and personal care and at the same time put our NHS back together.

"The NHS is loved. The public model that looks after everyone is loved. And in the NHS Reinstatement Bill – not this Commission Bill – we already have a model to ensure our NHS remains for future generations."

The storm and the fury

The dangerous liaison with the "7-day week"

Hearing our Prime Minister and Secretary of State confidently asserting that thousands of patients die each year because of a weekend effect, to be remedied by changing junior doctors' contracts, the average person would expect that they had a point.

But a review of the evidence does not support their conclusions and some of their claims have been rebutted very publicly.

Fiona Godlee, editor of the *BMJ,* wrote to Jeremy Hunt, as reported in the BMJ

She said that the article, by Nick Freemantle [1], professor of clinical epidemiology and biostatistics at University College London, and colleagues, reported an analysis of 30 day mortality after admission to hospitals in England and found an excess number of deaths among patients admitted at weekends. It found that 11,000 more people die each year within 30 days of admission to hospital on Friday, Saturday, Sunday, or Monday than on other days of the week.

She commented that she received a civil reply some weeks later where he spoke of more general issues, not addressing the specifics.

It was discussed on Radio 4's *Inside Health* programme where it was put to Professor Freemantle that the comparison of weekday and weekend admissions was not valid for the obvious reason that weekday admissions included many who were undergoing elective procedures and therefore significantly fitter than the weekend admissions, almost all of whom were emergencies. His reply was that a statistical adjustment was used to make the two groups of patients comparable.

The muddled thinking arises from three misconceptions:

1. That the casemix of patients being admitted at weekends is the same as on weekdays – clearly not so for the reasons previously rehearsed, notably the lack of routine elective admissions at weekend.
2. That putting on more juniors at weekends, as opposed to consultants radiographers, GPs, social workers etc, would make any difference to mortality.
3. That putting on more juniors at weekends will mean the number on during the week will remain the same. Again, clearly not so without more funding and extra juniors.

If this is not to be, Wednesday will become the new Sunday. And how will the Department of Health measure the "success" of the scheme? If the same numbers of juniors are evened out over the whole week and if juniors are important in reducing mortality, there will be a levelling down in care on all days of the week.

There will be no good or bad day but overall more people will die 3 months after being admitted on a weekday than did previously.

This will be interpreted as a good thing because the discrepancies have been ironed out. The absurdity of using these numbers is further illustrated by pointing out that significantly fewer patients who are actually in hospital at weekends die at weekends compared with those in hospital on a weekday, for example Wednesday [2].

How can we correct this scandal? Surely by putting the weekday doctors onto the same rotas as doctors working at the weekend. Job done!

In respect of excess stroke deaths, the presenter asked Dr Margaret Mc Cartney, a regular *BMJ* columnist, about the claim "you are 20% more likely to die from a stroke at the weekend. Where has that figure come from?" Her reply:

> "This was from a study published in the journal *Public Library of Science* last year. And on the face of it the numbers are correct. The problem is the numbers are now very much outdated. Their study looked at people who'd had strokes in the UK between 2004 and 2012 and the problem is that over that time, and even now, stroke care in this country has been revolutionised – we have these things now called stroke units, dedicated hospital wards where people with stroke are admitted immediately to, they're given very rapid scans, thrombolysis – clot busting drugs if they're needed – rapid physiotherapy, rapid speech and language assessments, swallow assessments. Care of stroke patients in this country really has changed dramatically over the last 15 years or so and I think it is really folly to start to think that we have a problem now that has not been changed because I do think that we cannot compare what's happening now to what was happening then."

The whole programme can be downloaded as a podcast at http://www.bbc.co.uk/programmes/b06wd7f4 (the link includes a transcript).

The government's thinking has been described as "muddled" by the very man they have chosen to help ACAS broker the deal between the BMA and NHS England, as reported in the *Health Service Journal*. David Dalton said it was vital the NHS focused on reducing and eliminating "unwarranted variation" across 7 days and that doctors in training are the group that will be least affected.

Sir David speaks with much knowledge

of the subject as he is the CEO of Salford Royal, credited with achieving a "7 day service" which has been applauded by both Hunt and Cameron. They have advocated that all hospitals should seek to achieve this level.

Yet, reading the comments from doctors working there, it does not sound too different from any other well-run hospital with good levels of cover for emergency services but no elective lists at weekends. In a statement given to The *BMJ*, Pete Turkington, medical director at Salford Royal NHS Foundation Trust, outlined the trust's approach to 7-day working: "Our vision of a 7 -day service at Salford Royal has been primarily focused on providing reliable and standardised emergency care every day of the week. It has never been our intention to have a full 7-day elective service."

The inconvenient truth for the government is that their megaphone diplomacy has disrupted the progress being made on improving care. As a haematologist with immunosuppressed patients, weekend visits have always been the norm, and I have always seen consultant colleagues at work then.

The work of the acute physician now involves 12 hourly ward rounds, 7 days a week as standard. There have been working parties on a regional basis to oversee and report progress in meeting standards.

The storm and the fury could well yield little more than damage to the NHS in a flood of misdirection and misunderstanding. To the detriment of us all.

References

[1] Freemantle, N., Ray, D., McNulty, D., et al. (2015) 'Increased mortality associated with weekend hospital admission: a case for expanded seven day services?' *BMJ*;351:h4596

[2] Crump, H. (2015) 'Seven day working: why the health secretary's proposal is not as simple as it sounds.' *BMJ* 2015;351:h4473

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Combining forces

A new start: or "same old"?

Last year Keep Our NHS Public took the lead in inviting groups that support the NHS to campaign together under a new "umbrella organisation", Health Campaigns Together (HCT).
After months of planning and more than a little negotiation, Defending the NHS, the inaugural conference of HCT, took place on Saturday 30th January in the London Welsh Centre.

Over 200 campaigners from all over the country gathered to hear the speakers and come up with ideas. Excellent presentations from well-known figures such as Clare Gerada and Louise Irvine were matched with equally compelling words and calls to action from students, health unions and fellow NHS campaigners.

Dr John Lister opened the conference, spelling out the problems: austerity meaning barely any growth by 2020, chaos from numerous contracts going to providers with little experience, making major errors and some companies brazenly aiming to win contracts on price without due regard for quality:

"The attack takes several forms. There's the freeze on funding since 2010: the meanest ever period for funding the NHS. In real terms, virtually zero actual growth. And the Stevens Plan is to find £22 billion of savings from the NHS up to 2020. This is austerity, big time, in the NHS.

"But on top of that we have the chaos caused by Andrew Lansley's Health and Social Care Act. The deliberate fragmentation. The deliberate organisation of the NHS to open up as much possibilities for the private sector as they possibly could.

"We have over 200 CCGs obliged by the legislation to put more and more services out to tender and even in some cases doing so, with conflicts of interest meaning contracts are starting to go to places where GPs are having a personal financial interest as well. Other GPs drawn on to the CCGs have decided it's too much work and have pulled out. Some trusts are massively expanding their private work.

"Even where a competitive tender goes to an NHS-led group, we have the chaos caused by contracting. The millions wasted in consultancy fees. The management time diverted from frontline patient care. Dislocation of services as they are taken from one NHS provider and given to another, with all the chaos that creates.

"Then we have the chaos with GPs: we can't recruit or retain GPs and GPs are leaving for different countries, GPs breaking up at the strain of working 12-13 hour days; GPs finding their share of the national health budget is falling; and then Ministers say they want them to deliver a 7-day service, despite the fact no one wants them.

"This is the opposite of evidence-led policy. This is policy despite the

> "The attacks are part of an ongoing strategy so we will accept privatisation. We are not going to do that."
> *– Jenny Leown*
> *OHT student*

Health Campaigns To

evidence, that it's not working, it can't work. This is a sure-fire formula for wrecking the NHS."

A new and impressive voice was from Dr Yannis Gourtsoyannis from BMA junior doctors who described that the simple sincerity of their message "Not safe, Not fair" had won public support:

"The coming months are going to be an axial moment for the future of the NHS. My union's willingness to take a stand against this government is probably the most positive single development that has occurred in this country over the last 20 years. 50,000 junior doctors are waking up and seeing the bigger picture. They are starting to realise we are a crucial line of defence in the battle for multiple fronts. Some of us believe we hold in our hands the fuse to ignite the wider healthcare workers' movement in a common defence of the NHS.

"Looking ahead for the next few months, I am cautiously optimistic. We are doing well. The government is on the back foot. But ultimately we will need you – the members of all the organisations present here today.

"Just as the social democratic consensus began with the inception of the NHS in 1948, so too will the NHS be the sight of Britain's last stand against the all-consuming forces of austerity, of commercialism, and of Conservative dogma."

The conference heard, from DFNHS member Dr David Wrigley, that many GPs are disillusioned and at the same time many of them were holding a meeting to consider mass resignation:

"I have just come from another conference nearby: 400 GPs are gathered over the crisis and the collapse in general practice. There were a lot of angry doctors over there. General practice is on its knees. We have GPs having breakdowns, GPs having panic attacks, they are depressed, they are resigning, they are retiring early. We see one million patients a day in primary care. That is an incredible amount of patients. We are getting less and less resources. This government ignores everything doctors say. They are not interested.

"The funding for general practice as a percentage of the NHS budget has been reduced from around 12% down to around 7%. A systematic de-funding of general practice, and it is being coordinated by our politicians.

"There is a crisis of recruitment in general practice. Training places are unfilled. GPs are resigning early. One in three are considering retiring early.

"Hunt has caused a scare, with patients not going to hospital at the weekend because they think it's closed or there are no doctors there. When we have a 7-day interest, doctors have always worked 7 days. Patients are turning up on a Monday at their GPs or A&E even worse than they were at the weekend. This is down to Jeremy Hunt and all he is doing.

"General practice used to be the jewel in the crown for the NHS. It costs around £140 per patient per year that gives you unlimited access to a GP. It costs more to insure your puppy. Yet politicians just ignore us. They are not interested."

We are many, they are few...

"The funding policy is used to lever other in health service... a hospital sector and a of the health service; to provoke failure

– Dr Sally Ruane, healt

The government's plans to appoint another 5,000 GPs are now far fetched and current predictions are that 10,000 will leave.

Many speakers were from Lewisham – not surprising as the campaign to save

gether

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ıre in the service."

alth campaigner, Leicester

Gathering the good and the great: speakers at Defending the NHS (left to right); Dr Helen Fidler (Consultant), Dr Yannis Gourtsoyannis (junior doctor), Dr Louise Irvine (GP), Professor Clare Gerada (Chair), Dr John Lister (Keep Our NHS Public), Jenny Leow (student OHT)

the hospital has been a notable success over government plans. Dr Helen Fidler from Lewisham Hospital spoke of the consultants' support for the juniors and for the BMA's campaign. She raised many laughs through her description of the BMA, as an old club of comfortable chaps, small and often large "C" conservatives, not prone to taking to demos on the street. When such a pro-establishment group supports a strike it is time to take notice!

Equally encouraging were the contributions from the health unions. Christina McAnea, from UNISON, gave a chilling account of the attacks on the terms and conditions of NHS staff as their working hours and terms of service were made steadily worse, with the prospect of local agreements replacing national frameworks: just what the government wanted, to do away with national pay bargaining and introduce a "flexible" workforce. Meaning one compelled to work longer hours for less money, less security and less recognition:

"I can't see how this can possibly work. What we don't accept is that they should be saying to hard-pressed staff who work in the NHS 'It's just like working at John Lewis's; people need access 7 days a week, 24 hours a day.' It's not like working at John Lewis's. Because we are running a service for people who are usually at their most vulnerable, and that's why staff who work in the NHS are committed to what they do. We have to keep up this campaign. We're certainly working with the BMA and watching with great interest to see what comes out of their campaign."

Unite's Colenzo Jarrett-Thorpe painted as grim a picture:

"In Unite there are all sorts of things we want to focus on. As a trade union we are going to talk about pay, rewards and justice. Our own members have been suffering a lot. For example, 42% of our members said that they worked extra hours with no compensation, no pay, no time off in lieu.

"Fifty two per cent of our members have said their workloads have increased far more than it had done in the previous years. An astonishing 80% of our members when they were surveyed said that morale was worse than it was in the year before. Our workforce is suffering. Morale is at rock-bottom."

The workshops included one co-hosted with 38 Degrees, who have been successful in mobilising opinion both nationally and locally. They are open to suggestions for campaigns.

The need for simple messaging, centralising of resources, and strategic thinking and planning came out of these very strongly, as did the need to broaden the reach of campaigns locally to engage those they would not normally work with, and support for the junior doctors and a national day of action to accompany the second reading of the NHS Bill on 11th March.

A point often made was the change in language, and tactics to conceal privatisation, eg no company is big enough to buy the NHS outright but devolution schemes and hiving off smaller portions will allow companies to buy the smaller pieces.

It is easy to condemn gatherings of the like minded as being little more than an echo chamber of good intention. HCT has shown that early promise can bear fruit, and make every group stronger.

Conference details:
www.healthcampaignstogether.com

What does the NHS mean?

The need to save our health service can seem thankless – but looking to the principles gives grounds for hope

We are rightly proud of our NHS, celebrated in the opening of the London Olympics and more recently in the extended coverage in the *Guardian* with its detailed accounts of good work carried out by devoted professionals, often working beyond their contracted hours, and accounts of patients who have benefited. As more people become aware of the threats it's no wonder more of the normally reserved Great British Public are speaking up.

At meetings over the last year I have heard impassioned comments from people clearly unaccustomed to public speaking but whose genuine concern shone through as they made their points. The increasingly serious problem now has overcome the natural British reserve to talk about values and emotionally laden issues.

What is clear is that the NHS has provided a sense of security to those in need and to everyone else that they or their loved ones will be looked after at a time of need. The sense of security has developed from the knowledge that it is "Our NHS": publicly owned, publicly provided and publicly accountable.

Now less of it is publicly provided as the commissioners and providers place contracts for outsourced services. This also undermines public ownership and public accountability. When work previously carried out by NHS staff is outsourced there is no ownership by the NHS. Accountability depends on the contract which will have been agreed by the commissioners, meaning the NHS is becoming less of a provider and more of a commissioner.

Perceptions and conflicts

How does this affect the public's view? Increasingly they see new companies moving into NHS work and there is clear apprehension when people see the name of a new company in the familiar NHS surroundings.

Can we trust the new organisations to deliver the same co-ordinated care that we were used to? This is highly unlikely, the basic principle of outsourcing is to cut costs through delivering the most profitable parts of the service and avoiding the high-cost, low-profit areas.

We know the NHS is underfunded and some past governments have acknowledged this; we have always understood rationing. There is never enough to go round, for everyone to have all they want, but it has been done by the NHS fairly, ie clinically driven. The sickest are prioritsed, the less seriously ill will wait.

As opposed to commercially led rationing, which not only leaves those without the means to pay still at risk but also creates its own demand by "recommending" procedures and treatments that a publicly financed system never would: "A healthy person is someone who hasn't been investigated enough!" sums up this tendency.

"People sense that medical advice which is dominated by profit based interests will not always be in their interests" [1]: this is the nub of the problem with marketisation. As a health provider we can deliver various services. A possible example could be the diabetic leg with compromised circulation. If you send the patient to a surgeon s/he could quite probably do what s/he's good at, an operation to amputate the leg, scar nicely healed, patient discharged, hospital earns £ Thousands for a completed healthcare episode.

This would go down in the records as a successful treatment but is it the best outcome? If you send the patient to a diabetic physician s/he may preserve the leg but that means years of tedious outpatient appointments and the accounting system identifies continuous follow-up as a drain on resources, the financial benefit of an OPD episode is less than the operation.

I have known foundation trust directors to argue that this difference means they should concentrate on providing more high earning operations and fewer, less rewarding OPD attendances. The fact that the patient has benefited from keeping their leg does not enter the equation when the directors set their objectives for the future.

I have often heard them say "We shall prioritise elective activity over non-elective"; this is financial commonsense as elective work pays better. In practice it means they plan operations that are cancelled because the beds are full of the emergency admissions they did not

plan for. The plans made by FT directors have to prioritise activities that earn the most money. Monitor, their overseer, tells them to and CQC say they are inadequate if they don't.

Monitor makes its judgement on the basis that FTs are businesses oblivious to their commitment to respond to the health needs of their communities but hospitals need to treat the emergencies that come to them which is why the majority are overspent. We now have a market in healthcare but not enough funds to operate it.

Driving forces

In a marketised system, what drives treatment? The needs of the patient over time, or the short-term demands on financial resources?

Of course there is an argument to say that money not spent on any given patient can then be spent elsewhere: this is the utilitarian principle. But are we really saying here that the reason why hospitals promote cost-saving measures that may not be in a patient's best long-term interests is for the greater good? Is that what is in managers' minds as they allocate where the money is spent? Or is this focused firmly on the need to stay within (ever reducing, in real terms) budgets – is this the end in itself? Suffice to say I firmly suspect the latter.

One current concern is threat to DGHs, based on the principle of economies of scale.

Put quite simply, bigger is better with the added advantage that there will be fewer hospitals, people will have to travel further to reach them so will be less likely to attend. Some years ago I attended a large public meeting where the Board of Basildon & Thurrock Hospitals was advocating closing the hospital in Thurrock (Orsett hospital). The feelings ran very high – it was very clear that local people felt a strong bond and sense of ownership. It was also clear to me that the sense of loss was completely genuine and that they strongly felt it was their hospital. They felt it was theirs by right and that no one had the right to take it away. The rationalisers will be cynical about this as a trend to fewer larger centres continues: how to provide local services will be one of our greatest challenges.

Defining values

What does the NHS mean to us, in the midst of all this? The point I best remember is that it defines our values: fairness and consideration for those less fortunate, compassion and support for those in need.

One commentator said on Radio 4 recently that the NHS is like a religion – you daren't criticise it. He's half right – it does give a system of values. But it does a lot more. It applies those values and delivers in the real world. The best, concise description came from a woman, describing herself as one of the Darlington Mums after their Jarrow to London march: "It's compassion and co-operation in action".

> "It's compassion and co-operation in action"

Martin McKee's talk at the 2014 AGM compared the attitude to welfare in Europe and the USA. There is a better understanding thanks to the history of wars in Europe that you can lose everything through force majeure. Welfare gives you a second chance.

The NHS means security, trust – that the sick will be treated, freedom from the many consequences of illness. To quote from our website [2]:

> **"The NHS is the world's greatest ever example of a population agreeing to provide care for the sick. It exemplifies the ethos of civilised society, setting an example worldwide. Were it to become further eroded, it would be virtually impossible to recreate."**

The point is that the NHS has been trusted. We need to identify what's good about the NHS (goodwill and trust of all, patients and staff) to promote its success. Lest the materialists' ideal continues to erode it in the false belief that "the market is always best". When it comes to healthcare, that quite simply is not true.

Anyone wanting examples of how strongly a huge range of people, from unknown to famous, feel about the NHS can find them by viewing the "Bring Back the NHS" event hosted by Sir Ian McKellen on 25/4/15 which is easily found on Youtube [3]. This event was part of the pre-election publicity and it helped to inspire and to re-invigorate all who attended.

The event, like the 10 minutes in the Olympic opening ceremony and the *Guardian* articles, reaffirms our belief in the service. We do need to remind ourselves of this, as we need to summon the strength to fight the increasing threats to the NHS.

References

[1] Owen, D. (2014) *The Health of the Nation.* York: Methuen

[2] Doctors for the NHS (2016) 'About us' [online] Available at: http://www.doctorsforthenhs.org.uk/about

[3] Bring Back the NHS (2015) 'The NHS defines us as a nation' YouTube [online] Available at: www.youtube.com

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The still, clear voice of reason: An appeal

FOR THE NHS NOT PROFIT

OUR NHS

***OurNHS* is one of the few constantly critical sources of news stories about the NHS. Mainstream media regularly turn to them for information they know is reliable, and often directly opposed to the government "spin" being churned out to defend the actions behind the fragmentation and privatisation of our health service.**

They run on a shoestring: but even a sturdy pair of reliable shoes needs new shoelaces every now and then. And *OurNHS* needs your help: a very little, comparatively speaking. The following appeal can also be found on their website:

https://www.opendemocracy.net/ournhs/save-ournhs

"The public trusts doctors, nurses and health professionals far more than it trusts politicians or journalists. Politicians attack 'greedy' or 'militant' doctors and 'callous' nurses merely to deflect criticism of their own mismanagement – and to distract attention from the corporate influencers who are setting the NHS up to fail.

"As government tries to divide health workers and patients, *OurNHS* publishes the truth behind the spin. Our campaigning journalism aims to protect and restore England's NHS as a comprehensive, publicly funded service.

"And now we need the help of people like you – who know the NHS best – to step in and help keep our work going.

"On very low running costs, *OurNHS* regularly breaks the stories the mainstream media miss about the crisis faced by the NHS. Rich in voices from frontline doctors, nurses, ambulance workers and other health professionals, it exposes the government's misuse of statistics and critically examine its NHS policies – many of which are disruptive, evidence-free, ideological nonsense.

"In just the past few months we've exposed the betrayal of government promises to protect safe staffing levels and whistleblowers, the attacks on NHS staff pay, conditions, training, and trade unions, and the cuts and privatisation affecting both staff and patients. We're an invaluable resource to NHS staff, patients and campaigners fighting against these disastrous changes.

"But now we need your help. Already, readers contribute one-third of *OurNHS* running costs: a testament to our value. But our two main 'start-up' funders sadly can longer support us – so we're asking people like you who know the NHS best to step in and keep our vital work going.

"£15 a month would secure the future of *OurNHS* – or pay for just one minute of childbirth in a privatised, US-style healthcare system.

"If you prefer to make another one-off donation, that would be a huge help too:

"£100 would fund one *OurNHS* article* – or get you one dose of IV-drip in a privatised, US-style healthcare system.

"If we don't act now, the profitable parts of our health service will be sold off piecemeal, and we'll end up with a low-grade US Medicare style service while the wealthy buy themselves out of the system.

"Join us as an *OurNHS* supporter today, and we'll continue our fight to save the NHS."

> "*OurNHS* is a hugely valuable resource for all of us who care about the NHS, and want to understand how we can fight to protect it."
>
> *– Dr Louise Irvine, GP and Chair of the Save Lewisham Hospital Campaign*

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What a Cambridge circus!

Damning failure of Cambridgeshire contract

One of the largest NHS "market" contracts to date collapsed this month. The £800 million (originally £1 billion) deal to provide NHS care for older people in Cambridgeshire and Peterborough failed after only 8 months, deemed "financially unsustainable".

So what does this mean for the future of health care in the region? And for the government's preferred – and expensive – approach to offering up NHS contracts?

Back in 2013 Cambridgeshire NHS bosses created the largest potential privatisation to date. They claimed that only by offering all older people's healthcare to private sector bidders, could they deliver the "innovative" services needed, "joined up" with social care.

The controversial contract – delivered through the largely untested model of "outcome based contracting" – included bold promises to reduce nearby hospital admissions by 20%.

As private firms like Virgin, Care UK and UnitedHealth submitted bids, a huge public backlash followed – including a successful legal challenge by local campaigners to find out more detail on the plans. Several private bidders including Capita, Circle, Serco and Interserve pulled out, citing "affordability concerns"'

A new NHS "Uniting Care Partnership" (the local acute and mental health trusts) eventually took over, after a bidding process that cost the CCG over a million pounds (and cost the NHS hospitals that had to fight off the private health firms considerably more).

Predictably perhaps, the "Partnership" has now found they couldn't deliver the promised outcomes for the money on offer, either.

There were problems from the start. Disputes with neighbouring hospitals including Peterborough and Addenbrookes over the promised service levels. Complaints from GPs that the new service was worse than the old, award-winning NHS provider, Cambridge Community Services. Patients unimpressed when the boasted-about "integrated one phone call"'service turned out to be run by an ambulance trust based in a completely different part of the country.

The whole sorry story shows how, far from magicking up "efficiencies", elaborate outsourcing schemes and grand "integration plans" are achieving little and wasting huge sums.

Will the government heed the disaster and stop pushing such models on local NHS trusts? The runes aren't promising.

Similar "outcomes based" "lead provider" contracts are being implemented in Staffordshire (given its history, a soft target for experimentation) and more recently pushed in Warwickshire.

NHS boss Simon Stevens (formerly adviser to Tony Blair and then Vice President of United Health) is a fan – in his first post-election speech this year, he praised "outcomes based" measures of success. In the same speech he scrapped key old-style success measures - what he called "too mechanistic" targets for safe numbers of nurses – prompting both howls of outrage from campaigners Cure the NHS who saw that government promises post Mid Staffs had been betrayed – and widespread concern from experts including Sir Robert Francis, author of the report into that tragedy.

"Outcomes based commissioning" sounds great – who doesn't love a good outcome? We are told this is a more "patient-focused" approach than the current system where hospitals are paid per procedure and set targets for things like waiting times.

But "outcomes based commissioning" is no solution to the marketised mess in the NHS.

Earlier this year *OurNHS* exclusively exposed how outcome-based contracts gave the successful private bidders (like Virgin, in East Staffordshire), a blank cheque to write their own outcomes – and how they made it difficult if not impossible for the public to hold those providers to account.

The contracts are also likely to favour private providers with deep pockets, who can go into debt whilst the "outcomes" are awaited.

There are many questions on how the "outcomes" are set, and how they are evaluated.

More traditional targets for nurses and beds – used as a measure of the adequacy of healthcare provision - are slightly "clunky" proxy measures, it's true. But these old-style, concrete, easily quantifiable measures are also easier for patients and communities to fight to defend, and a lot harder to "game", than subjective "outcome" measures like "I had good care for my dementia two years ago" (as used in early "'integrated care" pilots like Torbay) or "my relative had a good death" (as used in the big cancer contracts).

Anna Pollert of Warwickshire Keep Our NHS Publlic also raises concerns that outcome-based contracts will "lead to perverse processes, and actually distort proper planning."

Keeping people out of hospital, for example, may be desirable – but incentivising profit-making providers to keep patients out, may lead to a US-style situation where patients with "Accountable Care Organisation" plans (ACOs) struggle to get admitted to hospital when they desperately need it. US-style ACOs are approvingly cited in Simon Stevens' plan for the NHS.

In fact, outcome-based measures are just yet another market-based approach, put forward by people who can't – or won't – envisage returning to a system where something other than financial

incentives drives activity and outcomes.

People who simply don't get the idea that professional integrity and a public service ethos in the NHS has generally ensured that patients are neither under- nor over-treated, without the need for complicated financial carrots and sticks.

People like the shadowy Strategic Projects Team – a nominally NHS organisation made up largely of management consultants on secondment from the big 4 accountancy firms – who are busy pushing this same model in Warwickshire, despite opposition from the local County Council and campaigners.

This is the same team responsible for the disastrous "franchise" privatisation experiment at Hinchingbrooke, which collapsed with devastating failures in patient care – and the expensive abandoned procurements for George Eliot Hospital and Weston Area Health Trust.

"Outcomes based contracting" is also pushed by the even more shadowy COBIC consultancy (a consortium of private firms including PWC, "Social Finance" and others) who've been developing the system and trialling it in their own backyard in Oxfordshire, as well as in Croydon and elsewhere, despite concerns from local health bosses, campaigners, and even experts in the Department of Health itself, who criticised its "major risks". The system has already had to be ditched for maternity services.

But "outcomes-based" contracting has had influential political backing from Paul Corrigan. The name may be unfamiliar but the NHS trade magazine *Health Services Journal* votes Corrigan "one of the top 100 most influential people in healthcare". The consultant is a former advisor to Health Secretary Alan Milburn, and to Tony Blair himself (a role he inherited from none other than Simon Stevens).

Amongst other activities, last year Corrigan co-authored a paper with COBIC boss Nick Hicks, where they admitted that a shift to "outcome based" contracting would cause "some turbulence in the system" but went on to dismiss concerns as "reaction from conservative staff more interested in preserving the present form of their institution rather than improving the service to the public".

There's little sign of contrition about the collapse amongst the local Clinical Commissioning Group either. They said in a statement:

> **"Patients and frontline staff will see services remain despite a contractual arrangement between Cambridgeshire and Peterborough Clinical Commissioning Group and UnitingCare Partnership LLP ending. Unfortunately both parties have concluded that the current arrangement is no longer financially sustainable. We are clear that the innovative model of care for older people and people with long term conditions brings benefits for patients and the whole health and care system and we are all agreed that we wish to keep this model of integrated service delivery."**

But Margaret Ridley of Keep Our NHS Public Cambridgeshire should have the last word on the expensive collapse. She comments:

> **"This appalling situation is yet more dramatic proof that the policy of opening up health care to competitive tendering is a scandalous waste of time and money, creating huge uncertainty for staff and patients. Whilst campaigners do, of course, feel vindicated following the years of warnings about the outcome of this unnecessary and politically driven process, it does raise two major questions: What is going to happen now? And is anyone going to be held accountable for this shambolic mess?"**

Caroline Molloy
Editor, OurNHS

[*This article first appeared on the* OurNHS *website:*
https://www.opendemocracy.net/ournhs/caroline-molloy/biggest-nhs-market-deal-to-date-collapses
Reproduced with kind permission.]

Cancer care contract falls after Cambridge fiasco

The emergence of yet another failure in the privatisation experiment in Cambridgeshre prompted a "freeze" on the equally controversial plans to make the provision of cancer care in Staffordshire fall under the remit of a private contract.

The privatisiing of Cancer care services in Staffordhire has long been the subject of a battle for local campaigners, who formed the campaigning group "Cancer Not for Profit" (www. http://bit.ly/1QfPv3e) to fight the contract.

The £687 million deal to hand cancer care services in Staffordshire to a private provider has been "put on hold" [reported in the *Stoke Sentinel:* http://bit.ly/1QzSpis] while the inquiry is held into the disastrous failure of the privatisation contract for £800million of elderly care in Cambridgeshire after 8 months because it was financially unsustainable.

Gail Pearson has been a member of Cancer Not for Profit since it was founded:

"We are just delighted: if we hadn't have been doing what we've been doing this contract would have been awarded 18 months ago and would probably have fallen over before Cambridge did.

"In the interests of patients we now hope the whole thing will be scrapped completely. Financial problems were behind the collapse in Cambridge and given the soaring demand for cancer care from this fixed-price contract, surely that will apply here."

Meeting Heidi Alexander

The National Health Activists' Network arranged a meeting with Heidi Alexander, Shadow Health Spokesperson, in Westminster on 14th January to report problems in the NHS and hear her response. This network was set up, by the National Health Action Party and 999 Call For the NHS, following a successful demonstration against an NHS procurement conference that was actually about securing NHS services for private companies in Birmingham last year. It has a social media presence through Facebook and describes itself as "an honest grassroots campaign...going beyond party politics". Unlike Health Campaigns Together (see page 5), individuals can join "The Network".

The main contributors were from groups from 999 Call for the NHS, who also organised the Jarrow March for the NHS, which brought thousands to support them on reaching Trafalgar Square in September 2014. Their web site has this clear message: "It 's simple – remove the market and return the NHS back to us".

The meeting heard many examples of reduction in services from around the country, such as the report from Colin Hutchinson, below. Another example was from Sussex Defend The NHS, who reported that the contract for substance misuse had gone to an organisation who closed the inpatient services, meaning that patients undergoing detox would be moved to Islington, London! A classic example of a contract benefiting the provider but not the patient nor the community.

Many of the points made were against privatisation, with examples of multinational companies winning contracts resulting in public money ending up in tax havens.

Eric Watts asked Heidi for her views on the NHS Bill. She said she felt it was too big a reorganisation for the public to stomach and that her priorities were to hold the government to account on funding and to make care of the elderly sustainable given the cuts in social services.

She made good points in respect of support for the junior doctors and was optimistic that a settlement could be reached, on the pattern of services at Salford, which had good 7 day cover within the existing contract.

Her answers did not satisfy many present who wanted her to be more radical but she replied that she was nothing if not honest; she made it clear that she had come to listen and would make her own decisions.

Colin Hutchinson's statement

I recently retired from my post as Consultant Eye Surgeon in Halifax and Huddersfield, serving a population of half a million people.

For 10 years I was also Clinical Director for Head and Neck Services, so I was responsible for the management of not only the Eye Department, but also the Ear, Nose and Throat and the Maxillofacial Surgery Services. Between them, these departments accounted for a third of all out-patient attendances and a quarter of all operations, so a substantial number of patients attending the hospitals were under the care of these three departments. In addition, I led the Skin Cancer Multi-disciplinary Team, giving me an insight into the delivery of Dermatology and Plastic Surgery Services.

This made me very aware of the increasing difficulties that have been developing, in staffing many areas of hospital-based medicine.

My wife trained as a District Nurse in 1992 and has worked as a District Nursing Sister in Aberdeen and West Yorkshire, later as a Manager of District Nursing Services and subsequently as an Advanced Nurse Practitioner in Community Nursing and, through her, I have been aware of the increasing problems of providing services in the community setting.

No interest in training

The NHS depends on people to make it work – you could have the best buildings and equipment money can buy (in your dreams), but take away the staff and it is nothing, and yet there has been a criminal neglect in developing and maintaining an adequate level of trained staff in many crucial areas of the service.

In part, this is a result of the fragmentation of NHS services into numerous financially autonomous trusts and other provider organisations, which have responsibility for providing clinical services, but no responsibility for the wider NHS. They have very little concern for the provision of a pool of trained staff, but they rely upon the wider NHS for the supply of future employees.

This responsibility has been vested in Health Education England (HEE), which in turn has little vested interest in the outcome of the training it funds. Because of the prolonged period required to train senior clinicians, the current crisis has been brewing for much longer.

These problems were brought to public attention last year, following the collapse of the Dermatology Service at Nottingham University Hospitals, and questions were raised in Parliament. The responses revealed that the collection of national data on staffing vacancies across the NHS was suspended in 2010, "to reduce the burden of bureaucracy", and reported that training of staff is now nothing to do with the Department of Health – it is the responsibility of local NHS organisations and Health Education England, so outside the remit of the government.

Each part of the system is working away in relative isolation and is failing the nation.

The car-crash which is the unfolding crisis in General Practice has been well publicised, even though there has been a totally inadequate response to

mitigate it and no significant increase in training numbers planned by HEE in 2016-17, but recruitment to fill Hospital Consultant vacancies is also a major problem in various specialties. The long-standing inability to recruit Consultants (and also non-Consultant grades) in both Emergency Medicine and Anaesthetics is well known and is one of the factors contributing to pressure to close one of the A&E Departments in either Calderdale or Huddersfield. It is proving almost impossible, despite the use of expensive locum staff, to maintain safe staffing rotas in the two separate hospitals. This is a situation mirrored in many places around the country.

Consultant shortage

Less well known is the shortage of Consultants in many other specialties. For example, there are nearly 200 vacant posts for Consultant Dermatologists across the country, but Health Education England is only increasing training numbers by 4 for 2016-17 despite this.

NICE requires the close involvement of Consultant Dermatologists in the diagnosis and management of malignant melanoma and other life-threatening skin tumours, but my trust has not had a Dermatologist in charge of the skin cancer team for 10 years, and many other trusts have similar difficulties. Hospital-based Dermatology services are also essential in the management of severe, uncomfortable and disfiguring skin diseases, requiring treatment of the immune system with potentially severe side effects, requiring expertise way beyond that available in community settings.

In Ophthalmology, one of the major causes of blindness is a group of conditions called glaucoma. This affects one in seven people over the age of 60 and makes up about 20% of the workload of most Ophthalmology departments. We have been unable to recruit a Consultant to lead the Glaucoma Service despite repeated advertising over 2 years: there is nobody out there from whom to recruit.

In other areas of specialism, we currently have two Consultant vacancies, with limited prospects of recruiting to them. When we do get responses to advertisements, we often only find that one candidate presents for interview; even if there are reservations about their suitability, it can be a difficult choice as to whether to take a chance with them, or to leave the post unfilled for a further 6-9 months, with its detrimental effect on the level service, and the pressure this can put on existing staff.

Our Maxillo-facial Service is provided as part of the service based in Bradford Royal Infirmary, but three of the Consultants there are leaving and again the potential recruits are non-existent.

Worsening conditions

For many years, arrangements were in place in which the employees of these trusts were paid enhanced rates of pay to work above their contracted time, so that the service could be held together by staff intimately familiar with the hospital and the patients. Over the past few years, these enhanced rates have been discontinued, making it much less attractive for staff to extend their working week, and increasing the need to employ more expensive and often inefficient locum staff, usually through agencies, to fill the gaps in service. This has unmasked long-standing under-staffing.

> "Inadequacies in the numbers of staff being trained are... compounded by the problems of retaining staff "

Following the 2012 Act, Commissioning of services was split between Non-specialised Services, which were to be commissioned by Clinical Commissioning Groups, and Specialised Services, to be commissioned centrally by NHS England. This was intended to ensure that patients suffering from uncommon diseases, or requiring expensive treatment from highly trained teams, could gain access to such treatment, which might fall under the radar of CCGs. It was also intended to support the centralisation of treatments or operations where the results improved with the number of procedures being carried out. The improvement in outcomes of stroke care following such centralisation in London has been used as an example.

This all sounds very reasonable, but it is contributing to recruitment problems in many specialties and the resulting slow strangulation of the District General Hospital. For example, in my own specialty, corneal surgery, also children's eye surgery and some areas of glaucoma surgery, services which have been provided locally for more than 20 years, have been defined as coming under the remit of Specialised Commissioning and are unlikely to continue. Surgeons who have trained for years to be able to perform such operations are naturally unwilling to work in hospitals in which they cannot put these skills to use, even if they only form a minority of their workload.

Patients who have corneal transplantation operations require prolonged specialist follow-up to ensure the best results and have a life-long risk of graft rejection so they will have to travel to the nearest designated "Specialist Unit", which is likely to be in Leeds for this, not just for the operation itself. Corneal surgery is only a relatively small part of the workload of a Corneal Surgeon – very many more patients suffer potentially sight-threatening corneal infections and other diseases. If there are no corneal specialists in the hospital, most of these patients will also have to travel to Leeds. This is despite the lack of any evidence of improved graft survival from such centralisation and as no expensive equipment is required, there are no cost benefits.

Poor retention

Inadequacies in the numbers of staff being trained are being compounded by

the problems of retaining good quality staff within the service. In part this is due to the actions of employing trusts: direct and indirect costs of employing staff represent about 70% of the costs of running an average NHS trust and, for more than 15 years, employers have been compelled to make "efficiency savings" of between 2% and 5%, every year. Essentially this means reducing staff.

Closing wards in hospitals and relative reductions in staffing levels in the remaining parts of the service have been obvious tactics used by trust managers, as well as altering the balance of experienced (more expensive) to inexperienced (less expensive) staff, through "skill-mix" exercises. The difference in salary between the higher and the lower grades of staff, particularly in nurses and others employed on "Agenda for Change" contracts is not very great, in many cases, and does not provide sufficient incentive for some very able staff to take on and persist in more stressful and pressured roles of managing under-resourced teams.

The result is that many high-quality staff feel under-valued and unsupported and leave the service many years earlier than necessary seeking other opportunities in which their contribution is better recognised and in which they are given the appropriate resources with which to do their work to a high standard; employing trusts are not necessarily unhappy about this as it helps them deliver "savings" in the short term, but it has a profound effect on the quality of service that can be delivered to their patients.

In part, however, staff retention has been affected by nationally-imposed factors:

- The preponderance of media and government-driven news stories talking down various aspects of the NHS service, while justified in some cases, is not balanced by emphasis of those areas in which the Service is performing well.
- The inspection regime of the Care Quality Commission is contributing to this denigration, but is hugely expensive and there is no good evidence that it is improving patient care.
- The organisational reorganisations occurring as a consequence of the endless negotiations in awarding contracts for various aspects of care ignore the fact that it takes a very long time to put together good healthcare teams, and to develop the knowledge to make best use of the other services with which you need to interact locally; private companies are often extremely skilled and well-resourced in bidding for such contracts, but often much less adept at delivering the quality of service required. Such uncertainties undermine the commitment to an institution that used to contribute to its stability and long-term development.
- The uncertainty of the future for the district general hospital in national planning.

Changes to the NHS Pension Scheme have produced a level of distrust in the levels of future benefits, prompting many staff with long service contributions to retire earlier than they might otherwise, to be certain of receiving a level of pension upon which they might have been relying. This is a temporary effect, which will gradually feed through the system, but is aggravating other current staffing problems.

> "In many areas of the country, there is no overnight District Nurse service"

Community failings

The standard response is that we are moving resources out of hospital settings into the community, which is supposedly much cheaper. But as the number of people with more serious illnesses, the number of people requiring palliative care in the hope of dying in their own homes, and the number of patients being discharged from hospitals at a much earlier stage of their recovery all increase, what is being done to ensure that there is the appropriate level of service in the community to look after them?

The overall number of nursing staff in the community has only increased by 0.6% in the last 10 years, so it is not as if there has been a significant strengthening of community nursing teams and, more significantly, between 1998 and 2013, the number of qualified District Nurses employed by the NHS has fallen by more than 40%. 35% of District Nurses are over 50 years old, so likely to retire soon, and yet the numbers of staff being trained to replace them is completely inadequate – in 2013, five new District Nurses qualified in the whole of London. 2014 was only slightly better, with 25 qualifying, but that is still far from sufficient to maintain, let alone increase, the provision of services in the community.

In many areas of the country, there is no overnight District Nurse service, so patients with indwelling catheters that go into urinary retention, or patients receiving palliative care in the hope of dying at home, or any one of a multitude of possible acute problems that could be dealt with in their own homes, have little option but to attend their A&E, and probably to be admitted while the situation is stabilised. This was certainly the situation in Waltham Forest in 2012, when I was looking after my terminally-ill father at home.

No investment

I found a similar problem in trying to recruit experienced nurses to fill vacancies in hospital posts, whether for ward staff or out-patient services. At the same time, there was a near total neglect in providing the opportunity for enthusiastic, energetic and intelligent staff to develop their clinical skills, or provide a pathway for them to progress within the trust and as a result, they would become dispirited and leave the organisation, or the NHS.

The result is that some parts of the service are left with a preponderance of less able, less ambitious staff, because they are less able to compete in the market for new posts. Part of the reason for this wilful neglect was that progression through the grades of experience increased the head-line cost to the employer and part was an unwillingness to accept the risk that one might make the investment in developing staff who could then jump ship to work for another organisation.

This short-sightedness is an inevitable consequence of the break-up of the NHS into a multitude of financially autonomous organisations. Rather than looking at staff development as being an investment for the whole NHS, and being funded nationally, regardless of where the doctor, nurse or other kind of staff may end up, it has become a financial risk to be borne by relatively small trusts. When so much of the managerial decision-making is based upon financial data, staff become an easily quantified drain on the assets of the trust, whereas the income that they generate for the trust is rarely documented, and less easy to measure accurately, to allow it to counter-balance the costs.

Secretarial neglect

The way that NHS trusts are treating clerical staff in the search for "productivity" is also proving counter-productive in many cases. Take the post of Medical Secretary, for example. This covers much, much more than typing letters. The secretary is the interface between the patient and the complex and bewildering hospital. A good secretary should enable the expensively-paid Consultant to work to their optimum efficiency. They arrange appointments for operations and investigations in a way that fits in with the overall treatment pathway, so that it works most effectively, and personalises it for that individual patient, such as making sure that transport arrangements and interpretation services are made available for those requiring them. If something crops up that means that the arrangements need to be changed, the secretary works with the patient to sort it out. If a patient or their carer has concerns about their care, they can phone their Consultant's secretary, who will either address the issues or find the appropriate person to do so. They are an essential member of the clinical team, but they need to be embedded within the team to have the intimate knowledge of the service required to sort out patients' problems.

In many trusts, however, Medical Secretarial posts have been slashed, down-graded, or both: the typing aspect of their work has been replaced by out-sourced typing services or voice-recognition software (which often requires a vastly increased amount of medical staff time to edit out errors).

The waiting-list management has been transferred to generic clerical staff, remote from the clinical team, with very little knowledge of the individual patients or the treatment planned for them, or its urgency, so that they cannot respond to changes in patients' circumstances or individualise their care, which can lead to cancelled operations or under-booked or over-booked operating lists.

Patient queries are put through to another generic clerical person, working in a kind of call-centre, who does not have the in-depth knowledge to address the patients' questions, all of which would then need to be forwarded to the Consultant to respond to, taking up a greater proportion of their time, and denying patients a prompt response to their concerns. The end result is that low-paid workers are losing their jobs and the work, which does not go away, has to be picked up by highly-paid medical staff.

Again, the tendency is for staff to be considered a financial liability, rather than an asset, and for them to be under-valued, down-graded and down-trodden, which is not a recipe for efficiency. Cost should not be the principal measure – cost-effectiveness should be.

Colin Hutchinson

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Under-fund

Years of under-s

Greater public investment is needed to fund the NHS at a level considered normal in other high income countries.

Health care is rarely far from the UK headlines, especially today, as junior doctors go on strike. The NHS's failings are often highlighted prominently, its successes much less so. There is a constant stream of warnings that it is running out of money and thus unaffordable. Those who never liked a tax funded system, which provides care regardless of ability to pay, continue to claim that the UK is somehow unique (it isn't – many other countries have a similar funding system) and that it will, at some time, be necessary to implement some other system, such as extensive patient charges.

Three years ago we published a paper in the *BMJ* [1] that analysed data from the Commonwealth Fund, a foundation based in New York, to show that, while the NHS was less generously funded than other health systems, sustained investment in the decade to 2009 had brought about substantial improvements. The Commonwealth Fund recently published a new set of data [2], covering developments up to 2013 in 13 high-income countries (Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States). We take this opportunity to follow up on our previous paper and assess how the UK is doing relative to these other countries.

As might be expected, the Commonwealth Fund's report focuses on the US health system, with its extremely high cost. The contrast with the UK is striking; its health care spending is the lowest of all 13 countries studied. In 2013, total spending on health in the UK was only $3,364 per capita (adjusted for differences in the cost of living). The average was $4,840 per capita but the US far exceeded this, at $9,086.

Even when we confine the comparison

d, discredit, privatise?

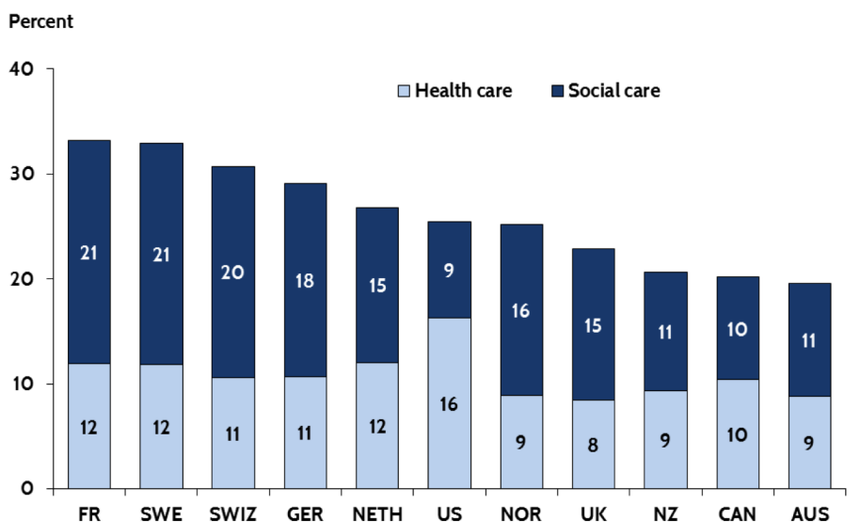
-spend must be overturned

to public sector (rather than total) spending on health care, a similar picture emerges in 2013. The UK government was among those that spent least ($2,802), with only Australia ($2,614) and New Zealand ($2,656) spending less per capita. Even the US, often thought of as a predominantly private health system, spends more public funds per capita on health care than the UK ($4,197).

The historical data in the report, on health spending as a proportion of Gross Domestic Product (GDP), are especially interesting. For most of the period between 1980 and 2013, the UK spent a lower proportion of its GDP on health care than any other country. By 2013 its total health spending was just 8.8 per cent of GDP; the next lowest spenders were Australia and Norway at 9.4 per cent, while the US, the highest spender, reached 17.1 per cent. Thus, whatever way one looks at it, the UK spends the least (or nearly the least) on health care compared to other high-income countries.

The UK does not spend much on social care (such as retirement and disability benefits, employment programmes, and supportive housing) either, at 15 per cent of GDP in 2013 as compared to 21 per cent in France and 18 per cent in Germany, for example. The strain that this places on the NHS, through delayed discharge, is well recognised. Our social care spending is, however, higher than in the US (9 per cent).

Given that the UK spends the least, it is hardly surprising that we also have fewer medical resources than most of the other high-income countries. The report shows the UK having by far the fewest Magnetic Resonance Imaging (MRI) machines (6.1 per million population, compared to an average of 17.85 across the countries for which data were available) and Computerised Tomography (CT) scanners (7.9 per million population, compared to an average of 33.8). Given strident calls to reduce hospital capacity, it is noteworthy that the UK has one of the lowest numbers of acute care beds (2.3 per 1,000 population compared to an average of 3.2).



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Health and social care spending as a percentage of GDP, by country

The UK's very low level of public spending on health care and its lack of medical resources compared to other high-income countries make a mockery of the notion that we cannot afford to spend more on the NHS. On the contrary, these data suggest that far greater public investment is not only very possible, but also necessary if the NHS is to be funded at a level considered normal in other high income countries.

References

[1] Ingleby, D., McKee, M., Mladovsky, P. and Bernd, R. (2012) 'How the NHS measures up to other health systems.' *BMJ* 2012;344:e1079 [online] Available at: http://www.bmj.com/content/344/bmj.e1079

[2] Squires, D. and Anderson, C. (2015) 'US healthcare from a gloabl perspective'. The Commonwealth Fund [online] Avaialble at: http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

[*This article, by Philipa Mladovsky, Martin McKee, David Ingleby and Bernd Rechel, was originally posted on the LSE Health and Social Care blog. Available at: http://blogs.lse.ac.uk/healthandsocialcare/2016/01/11/greater-public-investment-is-needed-to-fund-the-nhs-at-a-level-considered-normal-in-other-high-income-countries*]

Martin McKee

Article Review

Healthcare in New Zealand: how the problems associated with a competitive system were overcome

BMJ

At the end of March 2015 (28th), the *BMJ* published a short but rich paper describing how New Zealand had successfully repealed competition-based health law resulting in a "better, more integrated care system" [1]. This paper is summarised here as it seems neglected though highly relevant to the NHS in England.

The paper was written by Ian Powell, the executive director of the Association of Salaried Medical Specialists, Wellington, New Zealand; and professor Martin McKee of the London School of Hygiene and Tropical Medicine.

New Zealand has had a national health system since 1938. In 1993, the National (conservative) government introduced an "internal market":

> "As the 1990s progressed it became clear the new model was failing. It led to contradictory and perverse incentives, neglect of workforce development and planning (the legacies of which still plague the system), fiscal irresponsibility, and excessive transaction costs."

The election of a Labour-led coalition in late 1999 "marked a major break with the prevailing market forces ideology. The existing legislation was repealed and replaced by the New Zealand Public Health and Disability Act 2000." Note, the decision was to repeal and replace, not amend:

> "The state owned companies were replaced by district health boards responsible for the provision of a comprehensive range of health services for a defined population… The boards were not subject to the Commerce and Companies Act, and their scope was extended from tertiary and secondary services to include primary and community services."
>
> "The clear success of the Public Health and Disability Act generated broad political support. When the National Party returned to power in 2008, leading a coalition government, it strengthened the act, attracting support across the parties. By 2011 an independent analysis concluded that the Act had succeeded in integrating planning and funding…"

"The new model has proved resilient both to a change of government and ... to the February 2010 earthquake that hit Christchurch"

Powell and McKee conclude that the new model has proved resilient "both to a change of government and, in its greatest test, to the February 2010 earthquake that hit Christchurch…"

Reference

[1] Powell, I. and Mackee, M. (2015) 'Amend or repeal? How New Zealand tackled unpopular healthcare legislation.' *BMJ* [online] Avaialble at: *BMJ* 2015;350;h1502.

Peter Draper

Book Review

Deadly Spin: An insurance company insider speaks out on how corporate PR is killing healthcare and is deceiving Americans

Wendell Potter. Bloomsbury, 2013
304 pages (£12.84, Kindle £11.99)

Wendell Potter's career, from respected reporter to PR hack and back again, is a much a warning as redemption. It was his job to put a positive message behind the remorseless agenda of US health insurance giants. Which was and still is to take as much money from the US public as they can while coming up with as many reasons as they can not to pay out. And he was shamelessly good at it.

An ethical agenda more destructive to our NHS would be hard to find. Anything that detracted from the need to make money was held to be wrong, anything that promoted the myth that people were actually paying for something that would help them when at their most vulnerable and afraid was good. We see the inevitable legacy: millions of Americans left believing they are adequately insured when in fact these predatory travesties of health are striving to "de-insure" them from their work-place schemes or when they try to claim.

Why is this relevant? Because it is happening here. As trusts are compelled to "compete", as private providers move in, so too is the language of PR by and about the NHS changing. I see the shadow in the "Dark Side" of PR. It is growing.

Potter's book is the writing on the wall. Unlike the industry he left, it can and must be trusted.

Alan Taman

Book Review

The State We Need. Keys to the renaissance of Britain

Michael Meacher. Biteback Publishing, 2013. 296 pages (£18.99, Kindle £16)

In 1996, just before the Labour party won power, Will Hutton's book *The State We're In* won critical acclaim for its critique of laissez-faire capitalism, in particular deregulation, privatisation, asset-stripping and the destruction of our manufacturing base. Michael Meacher's hard hitting *The State We Need* brings that critique up to date and is more shocking for what it reveals.

Meacher argues that since the 1970s a new world order has been created by a cosmopolitan super-class consisting of financial and political elites.

On the one hand are the chief executives of the top multinational corporations, hedge fund managers, investment bankers and pension fund managers; and on the other, central bankers, finance ministers and key political figures. It represents a multi-trillion pound privatisation of the global economy's funding, largely outside of political control. In Britain big corporations have usurped much of the power previously invested in government and used it to divert public funds for private ends in a ruthless pursuit of wealth and power.

Hospitals, schools, roads and prisons have been tailored to meet corporate requirements rather than public need. Major companies have substantial lobbying muscle in Whitehall and are largely impervious to public influence.

Five of the UK's banks hold 85% of the public's money. What is the social remit of the banks? It doesn't exist. Bank culture is obsessed with overseas speculation, exotic financial products, property and tax avoidance. Banks have contributed just 8% of productive investment in the form of manufacturing, construction, communications, distribution, retail and wholesale.

The adversarial and impersonal model of UK-US banking is unheard of elsewhere in the EU. In Germany the sense of social cohesion is reflected in co-decision-making (*mitbestimmung*), in capital-market partnerships and long-term funding arrangements between regional banks and manufacturing industry. Regional government is entrenched and with reliable contracts offers institutional protection against unfettered market forces. This is unlike the US-UK emphasis on unrestrained globalisation and in part accounts for German anti-TTIP disposition in the EU parliament.

Since 1971 the numbers employed in UK manufacturing have drastically declined and those in finance have steadily risen. The latter have disproportionately increased their share of profits. Relative to GDP the UK finance sector is twice the size of comparable finance sectors in the EU. The fixation on quick-profit international speculation has crowded out funding for small business, industry and manufacturing. An overvalued exchange rate favours City investments abroad, but to the detriment of manufacturing needs at home. In the last 30 years there has been a sharp deterioration in the balance of trade in goods from a surplus of £1.3 billion in 1980 to a deficit of £106 billion in 2012, equal to 7% of GDP. Not forgetting the 2008 financial crash which cost UK taxpayers £1.2 trillion which equates to every man, woman and child in the UK having each paid the banks £20,000.

> "This is a powerful manifesto for a just nation….I urge you to read it"
> – George Monbiot (author, *The Age of Consent; Guardian* columnist)

Many other issues are covered including the environment and global warming. Meacher has six correctives for our current problems. Central to these is reform of our scandal ridden, poorly managed banks, so that they play a useful social role particularly in respect of servicing British industry.

Sadly, Meacher died in October 2015 at the age of 75 after a short illness. Born in Hemel Hempstead he won a scholarship to New College Oxford, graduated with a first class degree and then studied at the LSE. Before entering politics he was a lecturer in social administration at the universities of Essex and York. Meacher was first elected as MP for Oldham West in 1970 and served as a junior minister under Harold Wilson and James Callaghan. During Labour's time in opposition he was in the shadow cabinet for 14 years, and concurrently lectured at the LSE. He then became Minister of State for the Environment (1997–2003).

He was seen as a figure on the left of the party. Neil Kinnock described him as Tony Benn's vicar on earth. He married twice and is survived by his second wife and four children from his first marriage. When his safe Labour seat was contested after his death, the election was seen as a test of Jeremy Corbyn's leadership and the seat was considered at risk because of an anticipated UKIP threat. However the seat was won with an increased Labour majority and the Tories came third after UKIP.

The book is well written, well referenced and cogent. If you want an integrated account of our political and economic dysfunction, together with its remedy, this is the book to read.

Morris Bernadt

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