DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

Never!

... But it will unless we stop it:
The drivers of NHS finance – Page 14

Also in this issue:

JUNE 2016

CONTENTS

Doctors for the NHS Newsletter
Managing Editor – Alan Taman
healthjournos@gmail.com

Published quarterly. Contributions and comments welcome.

Back to Basics and Inconvenient Truths

These political clichés still hold true with respect to health. The basic facts are that good healthcare is not cheap and the inconvenient truth is that trying to make it cheap is counter-productive.

In a remarkable juxtaposition of recent health related news items on the Radio 4 bulletin at 8 o'clock on Tuesday 11th May, the first stated that the Ombudsman had criticised hospitals for sending patients home too early and the next that the public accounts committee reported a gap of 50,000 between the level of staff required to run the health service and the numbers in post (see page 23).

Training posts for vital staff have been reduced leading to cuts in services and cancellations. When hospitals cannot recruit enough full-time staff they have to turn to agencies for expensive replacements.

DFNHS is a non-aligned organisation of professionals but we need to face the reality that many of the current problems are as a result of government policy which needs to change to prevent further damage. Funding for the NHS peaked at 9% of GDP at the start of the century but is now down to 6.7%. Public health spending has been cut by 7%, described by the King's Fund as the "falsest of false economies".

The most important issues for us are to ensure adequate resources for the NHS and ensuring that they are used in the public interest, ie the greatest good for the greatest number, and that rationing – however explicit or concealed – should be on the basis of clinical need. But this is not happening and the NHS Support Federation continues to document contracts for services going to the private sector with further fragmentation, likely to keep the Ombudsman busy reporting on avoidable problems through a lack of organised and integrated planning.

DFNHS has been working on many fronts to make the case for restoring the NHS to its founding principles as reported in this issue which includes an abridged summary of the second newsletter from Health Campaigns Together, plus an interview with one of its editors, Dr John Lister (page 27).

The junior doctors are now considering the proposed new contract which, as the details emerge, appears to be a hard-won compromise. They made history by showing they were fighting for safe and sustainable working conditions not merely over pay. Their simple slogan "Not safe not fair" struck a chord which earned heartfelt public support, despite what could be termed the "dirty tricks brigade" attack using leaked documents (see page 20).

It is a truism to say that children are our future. I have included a piece on the early years (Page 8) and I am delighted to report that Professor Neena Modi, President of the College of Paediatrics, will be speaking at our AGM on 1st October in London. She wrote an excellent item in the *Guardian* in February [1] demolishing the myth that the NHS is unaffordable.

Finally, you can't have failed to notice that we are more compact yet undiminished! The change to this new A5 format was almost entirely down to costs: by switching, we almost halve the postage yet retain the same extent for virtually the same printing bill. In fact, by dropping the font slightly we even gain a little in our overall word total. This isn't the first time our newsletter has "gone mini"; it was an A5 format in its early days. So I hope you like it.

Reference

[1] Modi, N. (2016) 'Don't believe the myth that the NHS is unaffordable' *Guardian*, 9 February [online] available at: http://www.theguardian.com/society/commentisfree/2016/feb/09/nhs-part-privatised-health-service-complexity-costs-billions

Eric Watts
Editor
eric.watts4@btinternet.com

The Patient Voice

We work for our patients yet many doctors are disease centred rather than patient centred and doubt the value of patients' representation in policy formulation.

I have been particularly interested in this as I chose to study medicine after my experience of treatment for a neuroblastoma as a teenager. In those days, society was deferential to authority and doctors had sapiential authority. Also the spirit of benign paternalism infused the profession and "doctor knows best" was the unofficial strapline.

Now much has changed. Whereas I spent much time telling fellow students and doctors that patients weren't all dumb and could be involved in mutually respectful discussions and shared decision making, I now find myself defending doctors to patient groups who want more say on more of their doctor's time.

Numerous bodies and groups have put themselves forward as patient representatives and they all have some value. I am grateful to Charlotte Williamson, a sociologist who became a patient and who has written extensively on the subject and who has been on the editorial board of the *BMJ*, for the following.

She has described the rise of patient groups, showing that they can work well with health

Table 1 Attributes of patients, patient groups, and patient advocates

Attribute	Patient	Patient groups	Patient advocates
Personal experience of treatment and care in the specialty or place under discussion	Yes	Yes, most members	Sometimes
Knowledge of local issues of concern to other patients	Not usually	Yes	Yes, if in touch with local groups
Knowledge of issues of national concern and of the ideology of the patients' side	Not usually	Sometimes	Yes
Ability to represent views	Own voice only	Group's views, some of which will be common to other patients	In a general way, from a body of knowledge and principles derived from the experiences and views of patients and patient groups
Participation in working groups	On details of treatment and care	On specific services or specialties	On national issues, on standards, on ethical principles

professionals to improve care. Those who remember obstetric and childcare in the 1950s will remember needless institutionalisation which was challenged by groups such as the Natural Childbirth Trust (NCT).

Some members of the profession have been slow to respond – one *Drugs & Therapeutics Bulletin* on the subject had a cartoon with the doctor advising the patient "when we want your opinion we'll give it to you". A genuine problem though remains – does the patient speak for themselves or on behalf of all patients?

Charlotte composed the classification shown in Table 1which helps us to get a better feel for the value of patient reps.

We are making progress but a lot of work with patients is through top-down initiatives with tick-box questionnaires thrust at people about to leave hospital and in no state of mind for the thoughtful work that needs to be done to appreciate the patients' perspective. Dialogue with patients is improving.

Many patient groups have much experience that they can use to improve treatments and services. It is as much the medical profession's duty to listen to them critically and stop them sounding like a stuck record (surely an analogy that belongs as firmly in the past as the technology it sprang from) as it is in the patients' interest to be heard.

You Cannot be Serious!

John McEnroe leapt into public consciousness with his bratish behaviour at Wimbledon 35 years ago and it was fun to watch at the time. He found an effective way to get attention which is badly needed in health matters. The continued erosion of the NHS, the hollowing out from within of the core, the erosion of planned comprehensive coordinated care, continues and escapes press attention.

The latest King's Fund report [1] finds that nearly two-thirds of NHS trust finance directors and more than half of clinical commissioning group finance leads say the quality of patient care in their area has deteriorated over the past year. Performance has been poor: 3.7 million patients waiting for treatment, highest figure since 2007, 1.8 million waited for more than 4 hours in A&E, and 67% of providers ended the year in deficit.

Faced with these problems a responsible government would think hard then start addressing the problem realistically. There are precedents. I met Frank Dobson in 1998 when he was Secretary of State for Health and told him we needed more nurses, more beds and more doctors. "I'm doing the first two", he replied. And why not the third? "They take too long to train – someone else would get the credit for all the work it takes to achieve a real increase."

Such honesty contrasts with a recent conversion when the prime minister was boasting about his record on the NHS, specifically having created thousands of new GPs by 2016. A member of the audience asked how long it takes to create one; "around 7 years" came the reply. So Frank Dobson was right! John McEnroe was also right; but we do need to be serious.

Reference

[1] King's Fund (2016) *Quarterly Monitoring Report 19* [online] Available at: http://qmr.kingsfund.org.uk/2016/19/

Eric Watts
Editor
eric.watts4@btinternet.com

With the Juniors

It's in big letters... junior doctors offer Jeremy Hunt a first reader in understanding weekend statistics.

I write this on the 18th of May having heard that an agreement has been reached at ACAS, that there will be a guardian to prevent hospitals from exploiting juniors through overwork, and there will be a supplement for working unsocial hours.

The contract discussions have taken 4 years and became acrimonious in the last few months, we have published our support for the juniors' case for safe working conditions and recognition that working antisocial hours should be properly rewarded.

I have marched with our colleagues and joined them on picket lines and have been impressed at their commitment to the NHS and professional values. Finding myself, an older person, in their midst I would introduce myself and had many discussions. Almost all of them would say they did not want to strike but felt driven to make sure their case was heard.

Last year the demonstrations were good fun, high spirits with lots of jokes and banter. They made it clear they wanted to talk and as we passed Richmond House they would sing

to the tune of La Donna e Mobile, "Where are you Jeremy?" Various stunts organised to present the case showed humour, goodwill and creativity, such as the vigil outside Richmond House where junior doctors sat at a negotiating table awaiting the secretary of state; and the brilliant one where they created a poster-sized cover to the statistics textbook they presented to him (left) to help him understand the figures on mortality.

The anger and sense of outrage were clear, they were angry because of his glib assertions that they should work all hours and should give up more of the quality time they would need to spend with their families to have a healthy work-life balance. They made their points well. The government says it wants a 7 day NHS; they pointed out we already staff the service 7 days a week. There were posters and display boards with the names of junior doctors under the heading, "I would be here too Jeremy, but I'm at work".

This year the mood darkened. Posters on marches became more personal: "James Naughtie was right" (Mr Naughtie had mispronounced Jeremy's surname, using a "C" instead of an "H") and more party political, "The only safe Tory is a supposiTory".

The man holding the suppository banner told me he had read the Tory manifesto which, on the subject of 7 day NHS, had said that they would make sure the NHS was adequately staffed, not that they would stretch the working week putting staff on weekends and leaving gaps mid-week.

On the picket lines they were fully committed and well organised, with plenty of hot drinks from the hospital canteen and plenty of food and encouragement from other well wishers. I joined the Keep Our NHS Public group with the junior doctors at Southend, where many members of the public came up to thank them for the dedication they have shown.

Put simply, most people realised that no doctor wanted to strike but they weren't prepared to give in. They have seen worrying deterioration in NHS performance and an intransigent government bent on confrontation. Richard Horton wrote perceptively in his *Lancet* "Offline" comments that there was an untapped reservoir of anger against the Conservatives arising from the Health and Social Care Act, an anger that had been carefully preserved and nurtured, and that now it was being released.

This is unsurprising to anyone who has reviewed Jeremy's record: in 2005 he co-authored a book called *Direct Democracy* which called for the NHS to be dismantled [1].

His confrontational stance, declaring he would impose the contract, has lost him friends within his party and he has lost credibility through declaring that he was negotiating with Marxists intent on bringing down the government. One government minister admitted to Richard Horton that he had clearly made an error but "in politics, he said one can never apologise".

Does politics really have to be so confrontational? One of the interesting issues during the strikes was the public support for the doctors. Like the doctors themselves, no one wanted the strike but nor does anyone want to see a government minister try to force knowledgeable professionals into submission through tough talking and using false figures.*

Reference

[1] Hunt, J. (2005) In *Direct Democracy: An Agenda for a New Model Party.* [out of print]

*For a blatant example of "dirty tricks" against the junior doctors, see also page 20.

Eric Watts
Editor
eric.watts4@btinternet.com

Healthier Lives? Start With the Children

Professor Marmot, whose work is now known as the "social determinants of health", has described much illness as "failed prevention". Whilst most doctors would agree, we have been too busy dealing with doing the repair jobs on individual patients to give enough attention to fixing the causes.

If people lead healthier lives there would be less illness, but telling the arteriopath that their lifestyle is to blame does not help them; for lifestyle changes to work they must affect a major part of the lifespan. Naturally this means starting as early as possible and continuing education and public measures to ensure the improvements are embedded as the new normal. (For examples, the North Karelia project, begun 1972, had shown a 62% reduction in all cause mortality by 2006 [1].)

Put another way, if we could put what we already know about healthy living into practice, we would see less illness and better educational achievement with less demand on stretched NHS services.

The Marmot group made six recommendations. The first two relate directly to children. Those familiar with family health issues will recognise the vicious circle that must be broken: poor parenting, social deprivation, underachievement, early age pregnancy and poor nutrition, so the children may have suboptimal nutrition even in the womb.

Factors as simple as iron deficiency can have long lasting effects on intellectual development, which means that achieving the first of Marmot's objectives will require a healthy mother first of all. That is to say, we need a comprehensive approach and we all have a contribution to make.

What can we doctors do to help? Matilda Allen of the Institute of Health Equity has commented that we can play an important role in gathering and providing information, in order to tackle the causes of ill health. Gathering information from patients can help us to understand the ways in which social and economic factors are impacting on their health.

Health professionals of all specialties demonstrate an understanding and awareness of the factors that affect the lives of patients, their families, and the wider community, and many have done, and are continuing to do, important work on the social determinants of health.

In a broader sense, tackling health inequalities is likely to save the NHS, and the rest of society, considerable amounts of money [2] and is necessary to ensure both fairer health outcomes and a more sustainable health care system.

We hear justification of the contracts with the private sector on the basis of more choice but

The Marmot Recommendations

1. Ensure every child has the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

the most in need are the least able to exercise that choice. This is recognised by many governments, in the UK and abroad, that have responded with schemes to promote early learning. Educational achievement and health are closely related and it works both ways: being fit helps learning and the best educated lead longer, healthier lives.

In 1994, Sir Christopher Ball of the Royal Society for the Arts wrote a seminal report on early years learning stating its importance as a preparation for effective education and to promote social welfare and develop a world class workforce. He showed that countries benefit which provide pre-school education and commented that we paid a heavy price by not implementing the promise of nursery education for all stated in a government white paper of 1972. The author of that paper was none other than Margaret Thatcher, an indication of a consensus amongst politicians which makes it all the more important that it is put into place.

UNICEF provides regular reports of how rich countries fare in promoting child well-being. The latest Report Card, *Fairness for Children* [3], assesses "child well-being gaps", which measure the distance between the most disadvantaged children and the "average" child in each country. Writing in the British Politics and Policyblog, John Hudson and Stefan Kühner [4] conclude:

> **"More must be done to give the UK's most vulnerable children a fairer start in life as the UK is ranked 14th(from best) out of 35 countries. It ranks mid-table in three of the four child well-being domains: 25th out of 37 countries on educational achievement gaps; 19th out of 35 countries on health gaps; 20th out of 35 countries on life satisfaction gaps. The UK, in common with many other countries, has made little progress in reducing gaps in these child well-being domains since the 2000s."**

Sure Start: A worsening example

Sure Start was a UK government area-based initiative, announced in 1998, applying primarily in England with slightly different versions in Wales, Scotland and Northern Ireland. The initiative originated from HM Treasury, with the aim of "giving children the best possible start in life" through improvement of childcare, early education, health and family support, with an emphasis on outreach and community development.

Sure Start Children's Centres, controlled by local authorities, were to provide:

- In centres in the 30% most disadvantaged areas: integrated early learning and childcare (early years provision) for a minimum of 10 hours a day, 5 days a week, 48 weeks a year; and support for a childminder network.
- In centres in the 70% least disadvantaged areas, which do not elect to offer early years provision: drop-in activity sessions for children, such as stay and play sessions.
- Family support, including support and advice on parenting, information about services available in the area and access to specialist, targeted services; and parental outreach.
- Child and Family Health Services, such as antenatal and postnatal support, information and guidance on breastfeeding, health and nutrition, smoking cessation support, and speech and language therapy and other specialist support.
- Links with Jobcentre Plus to encourage and support parents and carers who wish to consider training and employment.
- Quick and easy access to wider services.

A 2007 study by researchers from the Universities of Oxford and Wales published in the *British Medical Journal* [5] looking at parenting interventions within the Sure Start system in Wales examined 153 parents from socially deprived areas and showed that a course teaching improved parenting skills had great benefits in reducing problem behaviour in young children. Parents were taught to:

- Increase positive child behaviour through praise and incentives.
- Improve parent-child interaction: relationship building.
- Set clear expectations: limit setting and non-aversive management strategies for non-compliance.
- Apply consistent gentle consequences for problem behaviour.

In 2010, robust research conducted by the National Evaluation of Sure Start [6] demonstrated significant effects of SSLPs on eight of 21 outcomes: two positive outcomes for children (lower BMIs and better physical health), four positive outcomes for mothers and families (more stimulating and less chaotic home environments, less harsh discipline, and greater life satisfaction).

Sure Start was a government sponsored nationwide scheme later devolved to local authorities but under the 2010 coalition government the centres began to close as the funding was not protected. Closures have continued with reductions in funding of local authorities.

We have become accustomed to the austerity measures but they are undoing the good work necessary for a healthier future for our children. The austerity agenda was introduced to reduce the national debt which has been given top political priority, but why? We are repeatedly told we can't afford the NHS with paying off the national debt cited as more important – but is this so and what's so bad about borrowing money? The national debt was almost two and a half times our GDP in 1949 and is now 70%. Adam Smith (arguably the architect of capitalism) said [7]: "Great Britain seems to support with ease a debt burden which, half a century ago, nobody believed her capable of supporting".

This newsletter has chronicled many attacks on the health of the nation and now we see the most sustained. In spite of the consistent high performance of the NHS in international comparisons this government seeks not only to undermine it but through austerity measures to further damage the social determinants of health.

We must continue the fight against austerity measures which harm the most vulnerable.

References

[1] Puska, P. (2008) 'The North Karelia Project: 30 years successfully preventing chronic diseases'. *Diabetes Voice*, 53, 26-29 [online] Available at: http://www.idf.org/sites/default/files/attachments/article_593_en.pdf

[2] The Marmot Review Team (2010) *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010.* London: Marmot Review Team.

[3] UNICEF (2016) 'Fairness for Children. A league table of inequality in child well-being in rich countries', April 2016 [online] Available at: www.unicef-irc.org/article/1323/

[4] Hudson, J. and Kühner, S. (2016) 'Unequal beginnings: more must be done to give the UK's most vulnerable children a fairer start in life', British Politics and Policy, 14 April 2016 [online] Available at: http://blogs.lse.ac.uk/politicsandpolicy/the-uks-most-vulnerable-children-deserve-a-fairer-start-to-life/

[5] Hutchings, J., Bywater, T., Daley, D., et al. (2007) 'Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial' *BMJ*, 2007; 334: 678 [online] Available at: doi: http://dx.doi.org/10.1136/bmj.39126.620799.55

[6] National Evaluation of Sure Start Team (NESS) (2010) 'The impact of Sure Start Local Programmes on five year olds and their families' Department for Education [online] Available at: http://www.ness.bbk.ac.uk/impact/documents/RR067.pdf

[7] Smith, A. (1776) *The Wealth of Nations,* Book V, Chapter 3.

Eric Watts
Editor
eric.watts4@btinternet.com

The Good, the Bad and the Ugly

A Review of *The Five Year Forward View for Mental Health.*
(A report from the independent Mental Health Taskforce to the NHS in England. February 2016. 82 pages.)

Following Simon Steven's *Five Year Forward View* for the whole NHS published in October 2014, NHS England set up a Mental Health Taskforce in March 2015 to create a new 5 year all-age national strategy for mental health in England. It reported in February 2016 and its recommendations are to be implemented by 2020-21.

The Taskforce has as its chairman Paul Farmer, the MIND chief executive, and vice chair Jacqui Dyer who is a user of mental health services. Membership is composed of representatives from NHS England (including Alistair Burns, Professor of Psychiatry at Manchester; and paediatrician Jackie Cornish), the Royal Colleges of Psychiatrists (Simon Wessely, president) and GPs (Maureen Baker, chair), the RCN (Peter Carter), the British Psychological Society (Jamie Hughes, president-elect), Public Health England, the CQC, Young Minds, Age UK, the Local Government Association, Monitor and nine other bodies. The perspectives of different contributors as reflected in different chapters range from good to spine chilling. The executive summary takes up the first 20 of the document's 82 pages.

According to the report, mental health problems represent the largest single cause of disability in the UK. Mental illness accounts for 23% of the total burden of disease, yet only 13% of the NHS budget is allocated to it. One in four adults experience at least one diagnosable mental health problem in any given year. One in ten children aged 5-6 has a psychiatric disorder and children from low income families have three times the rate of those from the highest.

The suicide rate is rising after many years of decline. The rise is most marked amongst middle-aged men. For men aged 15-49, suicide is the leading cause of death. Men are three times more likely than women to kill themselves and in 2013 accounted for four out of five suicides. People (the term "patients" is avoided throughout the document) with severe and enduring mental illness die on average 15-20 years earlier than other people.

Three quarters of people with mental health problems receive no support at all and of those that do, too few have access to the full range of interventions recommended by NICE which include medication and psychological therapy. The cost to the economy of mental disorders is estimated at £105 billion per annum, roughly the cost of the entire NHS.

The report makes 57 recommendations, many of them far reaching, which immediately brings into question their feasibility both in general and certainly within the time scale. Priorities are:

- (Oh no) a seven day NHS – a greater availability of crisis/home treatment teams which is good in its own right, but particularly geared to avoid admissions to a psychiatric hospital bed. Beds have reduced in number by 39% between 1998 and 2012. At present they have an average occupancy of 95%. Detentions under the Mental Health Act continue to rise year on year.
- Integration of mental and physical health approaches – people with long-term physical illnesses suffer more complications if they have co-morbid psychiatric disorder and costs go up by 45%. By 2020-21 at least half of all acute trusts are to have liaison psychiatric

availability including in A&E.
- Prevention at key moments in life – this lacks an evidence base.
- Building mentally healthy communities – there is welcome acknowledgement of the need for decent housing and stable employment in maintaining good mental health and of the importance of wider social determinants.

Child and adolescent psychiatry is recognised as being particularly under-resourced: "At least 70,000 more children and young people should have access to high-quality mental health care when they need it" including timely access to psychological therapies. Crisis and home treatment teams for children and young people are to be developed – out of area placements for acute care should be reduced and eliminated as quickly as possible.

There is to be a huge expansion in availability of psychological treatment for adults including those with psychosis, bipolar disorder and personality disorder. 600,000 people are to be treated, presumably over the 5 year period. There are recommendations for public mental health in relation to suicide prevention, primary care, perinatal psychiatry, rehabilitation and social psychiatry, old age psychiatry, addictions psychiatry and forensic psychiatry. In relation to research the Higher Education Funding Council for England is to check that "clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged [in funding] relative to other areas of health research, starting in 2016/17". There is to be a 10 year strategy for research.

The report emphasises:

(a) Treatment pathways following NICE guidance.

(b) Involvement of patients who have used the service in developing it. "All new models must be developed in partnership with 'experts-by-experience'", ie patients.

(c) Personal budgets (see below).

But "experts-by-experience" might not wish a service to follow NICE recommendations and an individual given a personal budget might well decide to spend the money on non-NICE recommended resources. How is this contradiction to be resolved?

£1 billion additional investment in mental health is needed and this has been accepted by NHS England. It is not clear how much of this has already been allocated in the £8 billion promised for the whole NHS after Stevens's FYFV.

Yet another body, a Mental Health Advisory Board, is to be set up to monitor the implementation of the report and to check on how the CCGs increase their mental health investment within their overall increase in allocation. Currently spending per capita on mental health across CCGs varies almost two fold. In 2010 the House of Commons Health Committee report on NHS Commissioning [1] concluded that there had been "20 years of costly failure" in commissioning in England. This FYFV mentions:

(a) Commissioning is to be underpinned by a "robust understanding" of the mental health needs of the local population. My view is that CCGs don't have the capacity to determine this and that the best guide available for most NHS services, probably especially in psychiatry, is given by who walks through the front door of the service.

(b) NHS England and "arm's length bodies" must ensure that commissioners are supported. They need "to build leadership, capacity and capability".

(c) Commissioners will "co-produce" (whatever that means) with clinicians, experts-by-experience and carers, but "work in partnership" with local stakeholders and voluntary organisations.

(d) There is uncertainty about the role and function of commissioners with all the changes going on. NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements are to be put in place to deliver the strategy.

(e) There has been too little scrutiny of commissioners and they must be properly held

to account. Currently providers carry much of the risk and responsibility for improvements in quality and outcome.

(f) "There needs to be a clear picture of the quality of commissioning".

Cometh the market fanatics: "There must be no more unaccountable block contracts for mental health". Providers might exercise flexibility in moving money around within their service, there would not be strict payment by results (in fact diagnosis) and the CCGs would not know how each penny is spent. National and local outcome measures should be used as part of the payment system. (Outcome measures take no account of case mix, the extent of provision of treatment and allied resources, and gaming of the system.) Experts-by-experience (patients) should play a leading role in developing outcome measures and payment approaches.

There is to be greater access to personal budgets in vanguard sites. In case you thought that clinicians had the best interests of their patients at heart, this document specifies that clinicians need to be incentivised by new payment approaches in order that they provide swift access, high-quality care and good outcomes. Financial levers are required to initiate change. Clinicians are unable to advise their patients about the most appropriate form of care, instead providers should be encouraged to appoint "navigators" to guide people through options for their care.

By way of gathering "public engagement findings", the Taskforce received 20,473 responses to a survey which was sent to service users, their relatives or close friends and (unspecified) mental health practitioners. The latter were a quarter of the sample. However there were complete answers to "around half or less" of the questions, for example key questions about age and gender. There were lower response rates from ethnic minority groups.

The authors couldn't code the large volume of qualitative data. Other methodological problems loom large. Instead of use of the paper re-cycling bin, the findings were published in September 2015 as *The Five Year Forward View Mental Health Taskforce: public engagement findings* [2]. A subsample of 2,434 respondents was used and one must assume that these were the more complete questionnaires. Wisely these findings are hardly referred to in the FYFV for mental health. The Taskforce might have been embarrassed that personal budgets came last in ranking of all measures to do with: bringing about change (10 measures), what is most important (10 measures) and priority for improvement (14 measures).

The Royal College of Psychiatrists states that it will play its part in making the objectives set out in the strategy a reality. My view of this document is that many of the proposed enhancements of clinical services are welcome, as is the increased but probably inadequate funding. However the whole 5 year development is mired in inefficient and costly marketisation. *The General Practice Forward View*, published in April 2016 [3], has been considered as grounds for a trade dispute and at a meeting on 20th May local medical committees voted unanimously to ballot the profession on strike action and the profession's willingness to sign undated resignations.

References

[1] House of Commons Select Committee on Health (2010) *Report on NHS Commissioning* (4th Report, HC 268-I) [online] Available at: http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/26802.htm

[2] Mental Health Taskforce to the NHS (2015) *The Five Year Forward View Mental Health Taskforce: Public Engagement Findings* [online] Available at: https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf

[3] NHS England (2016) *The General Practice Forward View* [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Morris Bernadt

"That's another fine mes

The legacy of NHS finances goes deeper and wider than the balance sheet

For most of us, there is a joy in practising medicine. Getting to grips with a huge body of knowledge, building on the experiences of august predecessors and applying it, every day, to improve peoples' lives through relieving suffering and disability. It provides intellectual stimulation, the opportunity to develop manual skills and give psychological and emotional support to other people, who are usually extremely appreciative of our efforts. You go to work to make a difference, and usually do. There are not many careers that can offer so much.

So why are so many doctors retiring at a relatively young age and why is there so much talk of low morale amongst us? Might part of it be that we experience too many obstacles, put in place, often with admirable intentions, that make the day's work like wading through treacle? To begin with, you can meet the challenge, but as the years go by it drains the enjoyment and you come to see just the barriers, rather than the way round them.

Struggling to find beds to admit patients that we know need to be in hospital; finding that your patients are scattered around a number of wards, where the staff do not understand their particular needs; loss of departmental secretarial support, leaving consultants as highly paid clerical staff with less time to offer direct care to their patients; interviewing the one candidate who has attended to replace a colleague who retired years earlier, after a recruitment process lasting 6 months, to realise that you have a stark choice – take a chance on appointing a candidate with underwhelming credentials and interpersonal skills, in the hope that your gut instincts are wrong, or go back to the start of the process and try and cope with the workload with a constantly understaffed department; these are all experiences that contrive to drain the colour from your life, like the spectres in Philip Pullman's books.

> "The NHS has been one of the most ... cost-effective health systems in the world ... Despite this relatively low level of spending, the Commonwealth Fund reported a higher level of public satisfaction than in other countries."

Why is it like this? As Bill Clinton said, "It's the economy, stupid."

Most of us have a mental image of what "good" looks like, and try to meet our own expectations, or exceed them, but we need to be given the tools to carry out the job and a good health service doesn't come cheap. On the other hand, poor health in the population is an economic drain: it reduces the productivity of the work-force, either through their own ill-health, through injuries or having to care for sick or disabled relatives. This economic argument was one of the driving forces behind the establishment of the NHS.

Overall, the NHS has been one of the most, if not the most cost-effective health systems in the world. The most recent OECD figures, referring to 2013, placed the UK as thirteenth

ss you've gotten me into"

out of fifteen countries, in terms of the proportion of GDP spent on health (private plus public spending), with only Ireland and Luxemburg spending less [1]. Unsurprisingly, the OECD reported a mixed score-card on health outcomes, with good performance in avoiding hospital admissions for diabetes and congestive cardiac failure, but below-average performance on survival rates in some common cancers, stroke and myocardial infarction, although rapidly improving. Despite this relatively low level of spending, the Commonwealth Fund reported a higher level of public satisfaction than in other countries [2].

In 2000, Tony Blair accepted that the NHS was under-funded compared with our European neighbours and many others. The UK was spending 6.3% of its GDP on health, whereas the EU average was 8.5%. He committed to matching this; note that he was only trying to match the average, not attempting to achieve the levels of France or Germany. By 2009, the NHS was receiving 8.8% of GDP; meanwhile the other 14 members of the EU had increased their spending to 10.1%. [3].

"Mr Hunt has made much of the £3.8 billion increase to NHS England's budget but ... the overall NHS budget has only gone up by £1.8 billion: ... the remaining £2 billion has been taken from staff training budgets ... and other areas."

There were many concerns at the way that this increased funding had strings attached, in particular the emphasis on commercialisation and competition; the proliferation of organisations providing death by PowerPoint in the name of showing us "new" ways of doing stuff; highly paid management consultants telling us stuff we already knew; and the reckless drive to modernise our dilapidated, Victorian work-houses that were our centres of excellence, with shiny new hospitals on the never-never, through Private Finance Initiative Schemes.

All the same, the extra funding combined with a small number of targets that focused the attention of hospital management structures, managed something that had eluded all previous governments in slashing waiting times for out-patient appointments and elective surgery, and massively improved public pride in the NHS.

As the UK shivers from the hang-over following the 2008 banking crisis, this rather surreal period of NHS history has come to a juddering halt. From a high point of 8.8% of GDP, UK health spending has dropped to 7.3% in 2014/15 and is on track to reach 6.6% by 2020/21 – similar to the level of funding before Blair's short-lived injection of resources. *The Quarterly Monitoring Report* from the King's Fund shows a continuing decline in the delivery of care to our patients and also in the optimism of Trust Finance Directors that they will be able to meet both their clinical and their financial obligations in the coming year [4].

But Jeremy Hunt remains chipper. When replying to a parliamentary question on 9th February 2016, on the financial deficit enjoyed by Bart's Health NHS Trust, he said: "It is stretching things to call this an austerity-driven problem when, next year, we are putting in the sixth biggest increase in funding for the NHS in its entire 70 year history." You have to admire his chutzpah.

John Appleby, of the King's Fund, has shown that, after adjustment for inflation, it is only the twenty-eighth largest since 1975-76, when comparable figures first became available [5].

Mr Hunt has also made much of the £3.8 billion pound increase to NHS England's budget arising from last year's Comprehensive Spending Review, but it took the Commons Health Committee to get him to clarify that the overall NHS budget for England has only gone up by £1.8 billion pounds: the remaining £2 billion has been taken from staff training budgets (Health Education England), public health, support for providers and other areas integral to the running of a national health service, to reduce the pain of NHS England [6].

John Appleby has also shown that, although the NHS budget will have increased in cash terms by £35 billion in the 11 years between 2009/10 and 2020/21, an increase of 35%, £24 billion of this will have been absorbed by inflation, leaving a real increase of just £11 billion. This equates to an average annual increase of just 0.9% [5].

Most of us have felt, directly, the impact of the scandalous way in which work-force training has been neglected since 2010. This was highlighted by the Parliamentary Public Accounts Committee and the National Audit Office, who concluded that trusts' projections of the staffing they would be requiring, and therefore the numbers of clinical staff that Health Education England would need to train, nationally, had been understated because of pressure from Monitor, the Trust Development Agency and NHS England to revise the numbers downward to meet the unachievable 4% budget savings that were being applied [7].

We are now reaping the consequences in terms of reliance on agency staffing and, more importantly, the long-term work-force shortages which are being used as an argument to remove hospital services from communities across the country through a huge programme of closures and amalgamations, rather than tackling the issue at source by a major increase in training of clinical staff. Health Education England has received flat-line funding this year, which gives them no scope to do anything but tinker at the edges and yet, where is the outcry from the Royal Colleges, Her Majesty's Loyal Opposition, the media, the public? It may take years to train clinical staff, but the sooner we get started, the sooner we will see some way out of this mess.

"I have a cunning plan"

So, if funding is only increasing marginally, and there is no political will to allocate a more reasonable proportion of the GDP of the sixth most prosperous country in the world to a project that has served this country well for nearly 70 years, but costs are increasing and demand for services is increasing, savings have to be made in order to keep the show on the road.

> "One of the main vehicles to achieve this level of cost reduction in the medium to long term is by a further massive reorganisation of the NHS in England, a bit like King Lear's plan for a comfortable retirement."

Simon Stevens' *Five Year Forward View* (FYFV), the plan for the NHS in England, which received strong cross-party support when it was published in 2014, has pledged to make "efficiency savings" of £22 billion annually by 2021. It was, however, only under questioning by the Commons Health Committee on 9th May 2016 that the detailed breakdown of these savings was revealed [8]:

- £6.7 billion to be delivered nationally:
  - Maintaining 1% cap on public sector pay growth until 2019-20.
  - Renegotiating the community

pharmacy contract (which is likely to lead to the closure of many smaller pharmacies, who have previously been seen as being important sources of health advice in the community).
- Implementing income generation activities overseen by the Department of Health (might this include sharing of health data with pharmaceutical, insurance and other businesses?).
- Reducing administration budgets for NHS England and Department of Health.

- £8.6 billion to be found from "provider productivity":
  - 2% per annum reduction in tariffs, to be offset by implementation of Lord Carter's recommendations, mainly in reducing the level of variability in the costs of delivering care between different providers, such as variations in cost of joint prostheses, rates of wound infections and staff sickness levels [9].
- £5.4 billion to be found from curbing the growth of activity through:
  - Moving care from hospitals into community settings (Right Care/Right Time/Right Place).
  - Promotion of self-care.
  - Restricting "interventions of limited value".
- £1 billion to be found from non-NHS provider contracts and reducing CCG costs.

"Pass the blame and don't blame me"

One of the main vehicles to achieve this level of cost reduction in the medium to long term is by a further massive reorganisation of the NHS in England, a bit like King Lear's plan for a comfortable retirement. The country has been divided into 44 parts, or Sustainable Transformation Plans (STP), each of which is responsible for staying within its centrally allocated budget: if it fails in this respect, it will have no access to any additional funding. Further funds will only be available through the "transformation fund". (Unfortunately, most of the fund for this year has already been spent in supporting various trusts' deficits.) Each STP will have had to produce a 5-year operational plan, to demonstrate how it will work within its budget, and have submitted it to NHS England by the end of June 2016 [10].

In my locality, West Yorkshire, the STP will plan and supervise the delivery of all health care for 2.5 million people, the second largest STP in the country, Greater Manchester being the largest. It will require close collaborative work between:

- 11 Clinical Commissioning Groups.
- NHS England Specialised Commissioning.
- Local government, through health and well-being boards and social service departments.
- Provider organisations, including NHS trusts, independent providers and social enterprises, covering acute services, mental health services, community services, specialist services and ambulance services.
- Local HealthWatch organisations.

So surely you would have expected wide-ranging discussions at many levels throughout the county…? Not a dicky bird.

If STPs were drawing up plans based on the accurate assessment of the health needs of their local populations and using that data to develop the most patient-friendly and cost-effective way to address those needs, one might give them a warm welcome.

They would have the potential to restore a co-ordinated strategy of co-operation between health organisations, rather than the competition between organisations, which has been the flavour of the day for the past 25 years. The Planning Guidance insists that this should be a planning process that draws widely on the experience of clinical staff, patients, carers, as well as managers in open discussion. It might even dove-tail nicely with the organisation envisaged in the NHS Bill, greatly reducing any disruption

if the NHS Bill were ever to be supported successfully by a major political party [11].

There is also, of course, the widely held and understandable fear that STPs could pave the way, sooner or later, for American-style Accountable Care Organisations, working within an insurance-based health service. You might think that: I couldn't possibly comment.

Unfortunately, once again, the process is being driven by the budget that has been allocated, and what can be afforded with it, rather than from the basis of the clinical needs of the population, with the risk that the most powerful and astute organisations might make an unseemly grab for whatever cash might be on offer. The planning phase is being rushed and seems to be a closed conversation taking place between a very few people, in a high degree of secrecy.

Certainly, for a gestation that is supposed to be delivered of a robust 5-year plan by the end of June 2016, I have been unable to find any clinician in my local CCG or acute provider trust who seems to have much idea of the importance of these plans to the future of local health services, or admits to having been involved in drawing up the plans. Public awareness and engagement is almost completely lacking and I have been unable to find any information on the web.

There is certainly the strong suspicion that STPs will be a convenient vehicle, far enough away from the government, to take the flack for locally unpopular closures of hospitals, down-grading of Accident and Emergency services, and implementing budgetary restrictions that would be likely to focus public discontent.

> "The PFI hospital needs to be kept open even if it means closing more suitable publicly owned premises... There is a correlation between large PFI building projects and hospital deficits and reduction in services and staff... You may have a state of the art building, but you can't afford to open it."

And to leave no tern unstoned

Costs of the market

Until the arrival of the purchaser-provider split in 1991, the NHS had largely been run without commissioners to act as intermediaries between the patient and the service treating them. This meant that NHS administration accounted for only about 5% of health service expenditure. The first hospital I worked in was run by the Hospital Secretary, the Matron and their secretaries.

After 1991, administrative costs soared, and in 1997 they accounted for about 12% of the total budget [12].

The Commons Health Committee, in 2010, became aware of a report commissioned by the Department of Health in 2005, which estimated the cost of the purchaser-provider split and management of the market accounted for 14% of the total NHS costs. The Committee expressed its irritation that the report had not previously been published [13]. No suggestion was made as to why the Department might have been reluctant to do so.

Another review of the costs of administering the market in health, published by the Centre for Health and the Public Interest, explained how difficult it was to separate out the financial costs of administering the market from other NHS management costs, but made a conservative estimate of them to be at least £5 billion on top of other management costs of the NHS [14].

It also elaborated on other destructive influences of the market on the provision of healthcare to the population of this country, and

the lack of any significant demonstrable public benefit [14].

Private Finance Initiatives (PFI)

Professor Allyson Pollock has made the observation that "In 1990, hospitals paid no charge on their land, buildings and assets; today, many PFI hospitals are paying more than 15% of their income. The figure is rising fast" [15].

In 1992, the Chancellor for the Exchequer, Norman Lamont, announced a new way of funding infra-structure projects which became known as PFI.

The use of this vehicle really took off in 1997, being embraced by the incoming Labour government, as a means of replacing the crumbling hospitals and schools from which many services were being provided. Unsurprisingly, this has left a massive financial burden for many decades to come, which sits on the balance sheets of those provider organisations, imposing a cost that cannot be reduced during straitened times, which is index-linked, so continues to rise year on year, and which forms an obstacle to restructuring of health services in any particular area, as the PFI hospital needs to be kept open, even if it means closing more suitable publicly-owned premises. As Allyson Pollock pointed out, "There is a correlation between large PFI building projects and hospital deficits and reduction in services and staff" [16]. You may have a state of the art building, but you can't afford to open it.

The *Daily Telegraph* gained access to figures from the Department of Health in July 2015 which showed that, nationally, PFI deals financed £11.8 billion of hospital building in England, but will cost £79 billion to pay back over 31 years. The annual cost in 2015 was £2 billion, but will have risen to £2.67 billion by 2030. The NHS Support Federation has also noted that 85% of the equity in these schemes is owned by international investment funds, with the greater part in tax-haven infra-structure funds [17].

Both the costs of PFI schemes and the market in health services are costly ways of running the NHS, limiting the money available to provide care to the population, with little benefit except to those businesses partaking in this perversion of the redistribution of wealth. In times of financial stringency, surely any responsible government would look at such areas of the health budget that do not deliver any value to the public, and would be pressed to do so by the Opposition parties?

So, at the end of the day, how should we tackle the waste of resources resulting from experienced and enthusiastic clinical staff losing the motivation to work effectively, or even from leaving the NHS entirely? I subscribe to the recommendation of the seasoned health service commentator, Roy Lilley: "Protect the front-line, fund it properly and make it fun to work there – and watch your troubles disappear" [18].

References

[1] OECD (2015) *Health at a Glance* [online] Available at: http://www.oecd.org/health/health-at-a-glance.htm

[2] Mossialos, E., Wenzl, M., Osborn, R. and Sarnak, D. (eds) (2016) *International Profiles of Health Care Systems,* 2015. London: The Commonwealth Fund.

[3] Appleby, J. (2016) "How does NHS spending compare with health spending internationally?" [online] Available at: http://www.kingsfund.org.uk/blog

[4] Appleby, J., Thompson, J. and Jabbal, J. (2016) *The King's Fund Quarterly Monitoring Report 19, May*. London: The King's Fund.

[5] Appleby, J. (2016) "How does this year's NHS budget compare historically?" 11 May [online] Available at: http://www.kingsfund.org.uk/blog

[6] Houses of Commons Select Committee on Health (2016) "Hunt MP questioned on health spending review" 9 May [online] Available at: http://www.parliament.uk/business/committees/committeesa-z/commons-select/health-committee/news/jeremy

[7] House of Commons Select Committee on Health (2016) *Managing the Supply of NHS Clinical Staff in England*. Commons Health Select Committee Report HC 731. May

[8] Dowler, C. (2016) NHS England reveals £22bn breakdown. *Health Service Journal,* 18 May

[9] Lord Carter of Coles (2016) *Operational Productivity and Performance In English NHS Acute Hospitals: Unwarranted Variation* [online] Available at: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

[10] NHS England (2015) *Delivering the Forward View: NHS planning guidance 2016/17 - 2020/21*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

[11] Houses of Parliament (2016) "National Health Service Bill 2016: Progress" [online] Available at: http//www.parliament.uk/bills/2015-16/nationalhealthservice.html

[12] Webster, C. (2002) *The National Health Service: A Political History*, 2nd edn. Oxford: Oxford University Press, p.23

[13] House of Commons Select Committee on Health (2010) *Commissioning.* Vol 1. London: Commons Health Select Committee Report HC 268-1, March.

[14] Paton, C. (2014) *At What Cost? Paying the Price for the Market in the English NHS*. London: The Centre for Health and the Public Interest.

[15] Pollock, A. (2012) 'How PFI is crippling the NHS', *Guardian*, 29 June [online] Available at: http://www.theguardian.com/commentisfree/2012/jun/29/pfi-crippling-nhs

[16] Pollock, A. (2013) 'PFI and the NHS in England' [online] Available at: www.allysonpollock.com

[17] The NHS Support Federation (2016) *PFI and the NHS in London* [online] Available at: www.nhsforsale.info/database/pfi-report

[18] Lilley, R. (2016) [online] Available at: http://www.nhsmanagers.net

Colin Hutchinson

A Dishonourable Attack

Much has been made of "leaks" from the discussions the Junior Doctors' Committee have been having, supposedly in camera, during the dispute. The *Health Service Journal* [1] reported on the leak of thousands of private e-mails from the Executive Committee of the JDC, and included claims that the BMA planned to draw out the dispute. Damning, you might think. Juniors regarded as mere cannon fodder?

However, Dr Yannis Gourtsoyannis is a member of the JDC and a prominent organiser of the juniors' strikes. At a meeting of Health Campaigns Together in May, he explained what was behind the revelation:

"There were several leaks....one of these was about discussions we had about our options going forward, and of course anyone who knows trade unionism will know that we had to consider everything from full capitulation to a full and definite walk-out...but that was never planned. The leaks have been not as damaging as they could have been but have definitely affected some of the internal dynamics of the BMA ."

[1] Lintern, S. (2016) "Exclusive: Huge leak reveals BMA plan to 'draw out' junior doctors dispute", *Health Service Journal*, 26 May [online] Available at: http://www.hsj.co.uk/topics/workforce/exclusive-huge-leak-reveals-bma-plan-to-draw-out-junior-doctors-dispute/7005113.fullarticle

TTIP: Remain to Gain?

The EU has taken steps to safeguard public services in TTIP

Set against the backcloth of all the noise surrounding the referendum campaign, across the UK there have been numerous worried newspaper articles, demonstrations, etc about the supposed potential dangers to our NHS and to other public services by this "trade partnership" currently being negotiated between the USA and the EU.

Indeed, in the form originally proposed by the USA, TTIP could have opened up public services to privatisation and being bought up by American-led multi-national firms. Yet there is, after all, a connection between the "Remain" campaign in the referendum debate and that against TTIP.

Many of the anti-TTIP articles in the press, and much of the noise at demonstrations, have been based on the assumption that there is much to be done to oppose it within the UK. In fact, trade, and all treaties concerning it, are entirely the competence of the EU, and not of member states (this is after all amongst the matters we shall be voting about on 23rd June). However, for those opposing TTIP, it is very good news that we are within the EU, as our UK government is in full support of completely free open trading with the USA, while the European Commission (EC) has given priority to the protection of European public services within TTIP.

The legal situation is that a draft treaty is being negotiated between the American administration (the Presidency) and the EC. If and when agreement is reached, the draft treaty would have to be ratified, by Congress in the USA, and by Council and Parliament in the EU. Voting procedures in the Council are complex, but essentially the treaty would require two thirds of the votes of member states (weighted for population) to be passed; the votes in favour of ratification needed from several major member states (eg France and Poland) seem to be rather in doubt. In Parliament, many MEPs, including the President of the Parliament, Martin Schultz, have made it clear that no such treaty will be ratified unless European public services are fully protected from any consequences of TTIP.

The progress of the TTIP discussions is fairly transparent, with all the EC`s negotiating positions, and many other related papers, being available for us all to read on the internet. It is another British misconception that fears that TTIP might endanger the way that health services (and other public services) are provided is a uniquely British phenomenon. In fact, this is far from the case, and there have been articles and demonstrations, emanating from several other major EU member states, very similar to those we have witnessed in the UK – with one exception! Our continental colleagues have been bright enough to realise that lobbying about this is remarkably useless at member state level and, wherever the demonstrations originate from (eg in Germany), they actually take place in Brussels.

The EC has noticed these, especially the Swedish responsible Commissioner, Cecilia Malmstrom, who is the person who negotiates TTIP with her USA opposite numbers. Her Swedish background may help her to be at least a little sympathetic with the demonstrators in Brussels, seeking to ensure protection for their health services back home. Accordingly, Ms Malmstrom published her negotiating position on the EC`s website (and on her own blog), indicating that she would guarantee the exemption of all EU publicly provided services from any TTIP treaty agreed. Clearly she has succeeded in getting US agreement to this, as in the EC document *The Translatlantic Trade and Investment Partnership (TTIP) – State of Play*

[1], dated 27th April 2016, it states on page 4 that: "Market access offers in this area reflect **the joint commitment from Commissioner Malmstrom and US Trade Representative Michael Froman that TTIP will safeguard the ways that national governments choose to deliver and run the public services they offer to their own citizens**" (the underlining is straight from the document; the bold is mine).

Moreover, to deal with another fear that has been expressed, that disputes (eg where international companies think that they might be able to sue member states` governments for lack of access to markets) might be taken to the arbitration system outside law which has applied to some other similar international treaties, it has been agreed that such a system will not apply to TTIP; instead, any such disputes will be resolved within a special new legal process.

Thus the Commission, responsible for TTIP negotiations, has already ensured some apparently pretty effective protections for the NHS in the UK`s four nations. However, as explained above, any draft treaty will have to be ratified by Parliament and Council. Leaving the Council aside (and doubts about Council`s ratification of TTIP at all have already been expressed), MEPs from the two main parties have made it very clear that any TTIP that does not fully protect European public services will not be ratified, and this position has been fully supported by the President of the Parliament himself, Martin Schultz, of the Socialist and Democrat Parliamentary Group (he is a German Social Democrat).

The Commission has established a TTIP Advisory Group, made up of representatives of major European NGOs and Commission officials, which meets monthly, to monitor progress with the negotiations and to identify any potential hazards; the European Public Health Alliance (EPHA) is a member of this Advisory Group. The minutes of the meeting of the Advisory Group held on 5th April show that 10 Commission officials (led by the Chief Negotiator, Bercero Garcia) met representatives of 16 NGOs, including Zoltan Massay-Kosubek of EPHA, and Susanne Logstrup of the European Heart Network, so health interests were well represented. The next round of TTIP negotiations are scheduled for the second week in July, and this Advisory Group will be monitoring any progress made in these discussions very carefully.

My conclusion is that our NHS and its protection from any hazards posed by TTIP are really rather effectively guaranteed by the way the EU institutions are operating in relation to the TTIP negotiations. If UK were to be outwith the EU, it would find itself to be a rather small fish in a big sea containing much larger fish, and in any international trade discussions its voice would be only a rather small one. It must be doubted if those larger fish would take account of many of the UK`s stated interests. Even so, if it could achieve a realistic international hearing, would any UK government seek to achieve equivalent protections to those offered to us by the EU? Certainly the present one wouldn`t, as it supports TTIP, apparently without qualification.

So in my opinion* it is fortunate that we are still in the EU, and on 23rd June we must ensure that things stay that way: this is the connection between the referendum and protecting the NHS from the potential hazards of TTIP.

Reference

[1] European Commission (2016) *The Translatlantic Trade and Investment Partnership (TTIP) – State of Play* [online] Available at: http://trade.ec.europa.eu/doclib/docs/2016/april/tradoc_154477.pdf

*The views expressed in this article are the author's and do not necessarily represent those of DFNHS.

Colin Hutchinson

Unstop Your Ears and Listen!

The latest Public Accounts Committee Report validates much of what DFNHS has been saying...if only those in power will heed it

Managing the Supply of NHS Clinical Staff in England.
Fortieth Report of Session 2015-16
House of Commons Committee of Public Accounts. HC731
2016. 26pp. [online] Available at:
http://www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/731/731.pdf

This report shows many of the current government's claims about the NHS to be what they are: ideology-driven wish-lists driven by belief, seeking out only the evidence the government wishes to promote and ignoring the rest. It makes for realistic reading.

The summary pulls no punches right from the start, and sets the tone for the whole document:

> "Over 800,000 clinical staff work in the NHS. Managing the supply of these staff effectively is vitally important…. However, the extent of staffing gaps in the NHS indicates that the supply of staff is not meeting demand. In 2014, there was an overall shortfall of around 5.9% between the number of clinical staff that healthcare providers said they needed and the number of staff in post, equating to a gap of around 50,000 staff.
>
> "This … inhibits trusts' ability to provide services efficiently and effectively, and could lead to longer waiting times for treatment and shortcomings in the quality of care."

It's downhill from there, really. The most compelling impression isn't that an accounts committee could have reached the conclusions it has – cries of "No sh*t? We've known that for years!" will be understandable from many readers of this magazine – but that any fair-minded and statesman-like government could possibly be ignoring what it says, but instead remain doggedly focused on what can at best be described as an impractical model for reducing the role of the state and at worst an inhumane inequality engine.

The summary continues:

> "In recent years, NHS trusts and NHS foundation trusts have focused on reducing staff costs in order to meet efficiency targets. This has led to them consistently understating how many staff they will need and resulted in gaps in staffing. At the same time, trusts had to ensure they had enough nurses in light of the failings in care at Mid Staffordshire NHS Foundation Trust …. Trusts met their need for more staff, in part, by using more costly agency staff….
>
> "The Department of Health and its arm's-length bodies have provided ineffective leadership and support, giving trusts conflicting messages about how to balance safe staffing with the need to make efficiency savings. In addition, overseas recruitment and return-to-practice initiatives, which could help address current shortfalls, have been poorly coordinated. The national bodies need to get a better grip on the supply of clinical staff in order to address current and future workforce pressures."

The report makes it points then draws its recommendations one by one with a clarity that leaves little room for doubt.

The main findings

National bodies have set trusts unrealistic efficiency targets

"This has caused the development of overly optimistic and aggressive staffing profiles which have subsequently led to staffing shortfalls. These have had to be met by increased use of agency staff.… NHS Improvement acknowledged to us that the 4% efficiency target in 2014–15 was unrealistic… trusts' workforce plans typically understated how many staff they would need…. Trusts were also under pressure to ensure they had enough staff following the failings in care at Mid Staffordshire NHS Foundation Trust.

"However, trusts could not recruit as many permanent nursing staff as they considered they needed and so filled the gaps, in part, with more costly agency staff."

Recommendation: "The Department, NHS Improvement and Health Education England should provide greater national leadership and co-ordinated support to help trusts reconcile financial, workforce and quality expectations."

Efforts to retain existing clinical staff are not well managed

"The cheapest and best way of ensuring the supply of staff is to retain the valuable staff that have already been trained…the proportion of nurses leaving increased from 6.8% in 2010–11 to 9.2% in 2014–15… it is not clear who is accountable nationally for controlling departure rates. The Department accepted that there is not enough data on why clinical staff leave the NHS and where they go when they leave."

Recommendation: "NHS Improvement should review trends in clinical staff leaving the NHS ... and provide us with a plan by December 2016."

The shortage of nurses is expected to continue for the next 3 years

"Trusts have not been able to recruit the nurses they need, and … the supply of nurses will not meet the demand until 2019–20. The shortage of nurses has been caused by a number of factors.

"First, fewer new nurses have been trained as the Department cut the number of training places in four consecutive years, with 3,400 fewer places commissioned in 2012–13 compared with 2008–09.

"Second, the number of nurses recruited each year from outside the European Economic Area fell by 10,700 in the decade to 2014–15.

"Third, fewer nurses are returning to practice than previously – on average 2,700 fewer returned each year between 2010 and 2014, compared with a decade earlier…. In October 2015, the Home Office added nurses to the 'shortage occupation list', which should make it easier for trusts to recruit from overseas…

"However, there has been little coordination of overseas recruitment and return-to-practice initiatives, with trusts potentially competing for the same staff."

This is possibly the most maddening, and plain mad, point: cut the people and force haphazard competition between organisations who can't afford to recruit but are forced to. Surely the most glaring example of marketising lunacy, with inept application of neoliberal ideals to a system they have absolutely no place in?

Recommendation: "The Department, NHS Improvement and Health Education England should set out a plan for how the shortage of nurses will be addressed over the next 3 years."

A bit lame, given the detailed criticism the committee went into. Why not specify a closer deadline date here as well?

The significant increase in agency costs is mostly due to higher volumes not higher rates

"This is largely the consequence of inaccurate headcount planning …. Spending on agency staff increased by half from £2.2 billion in 2009–10 to £3.3 billion in 2014–15…. witnesses gave the impression that the rise in agency spending was mainly due to increased hourly rates. In fact, the rise in spending is mostly the result of trusts needing to use more agency staff, often to cover vacancies…. The Department and NHS Improvement have introduced new rules that seek to control spending on agency staff, including mandatory caps on the hourly amount… However, they have not addressed the underlying causes of the increased demand for agency staff."

Recommendation: "As well as capping hourly rates, the Department and NHS Improvement also need to address the fundamental issue of the increased demand for agency staff; they should report back to us in December 2016."

A lack of affordable homes in some parts of the country is affecting the supply of permanent NHS staff

This expression of the crippling ramifications of the UK's peculiar wealth gradient expressed by the Severn-Wash line is something the current government is selectively deaf to, so seeing it in print is refreshing:

"Nurses and healthcare assistants find it virtually impossible to afford to live in some parts of London…. Trusts can pay staff recruitment and retention premiums and high-cost area supplements, but these are unlikely to enable many clinical staff to become permanently based in the areas where they work…. We are not convinced that the availability of affordable homes for NHS staff has been adequately considered as part of the Department's plan to generate £2 billion from disposing of surplus land….. ultimately, until the NHS addresses the lack of affordable homes, it will remain reliant on agency staff."

Recommendation: "The Department should set out how it will take account of the housing requirements for NHS staff."

Impact the proposed changes to the funding system could have on applicants for nurse, midwifery and allied health professional training

"The Government announced plans to reform the funding system for health students by replacing grants with student loans… the proposed changes also involve abolishing the cap on the number of student places for nursing, midwifery and allied health subjects… there are currently about three applicants for each nurse training place. However, there is no guarantee that this position will continue if the funding system is reformed and the changes could have a negative impact on both the overall number of applicants and on certain groups…. Health Education England told us that it had not assessed whether the changes would deter prospective students from applying."

Recommendation: "The Department and Health Education England should assess the likely effect of the new funding system on rates of applications … including whether the impact is consistent across different demographic groups and courses and how the changes are expected to affect the relative number of overseas students to home students."

No attempt made to assess headcount implications of major policy initiatives such as the 7-day NHS

Arguably the most damning section, given the juniors' recent need for industrial action:

"The Department has not adequately assessed the impact on the clinical workforce of implementing 7-day services, and so does not know if there will be enough clinical staff with the right skills. The 2015 Spending Review committed an additional £10 billion in funding for the NHS by 2020. The Department reported that this amount was intended to cover 7-day services, alongside meeting the other objectives set out in the *Five Year Forward View*. However, the £10 billion is a pot that the Department seems to expect will cover everything….We are therefore far from convinced that the Department has any assurance that the increase in funding will be sufficient to meet all of its policy objectives."

Could there be a stronger support for the juniors' case?

Recommendation: "All major health policy initiatives should explicitly consider the workforce implications, and specifically the Department should report back to us by December 2016 with a summary of the workforce implications of implementing the 7-day NHS."

A call to account, then – but will it be too late?

Limitations in the data on staffing pressures make it difficult to make well-informed decisions about workforce planning

"Data are not sufficiently reliable or comprehensive to support Health Education England's workforce planning decisions. An electronic staff records system is used by nearly all trusts, but there are limitations in the data that are collected and reported.… There is also no systematic information on why clinical staff leave the NHS, where they go when they leave, or why they transfer between providers."

Recommendation: "The Department… should set out how it will ensure there is systematic reliable data on workforce pressures, including vacancy rates and reasons why staff leave the NHS, to help them manage the supply of clinical staff more effectively."

"The Department told us there is no separate pot set aside for something specifically labelled 7-day services.... there was considerable overlap between initiatives and ... it had not separated out the money for 7-day services from funding for ... other objectives."

– Page 16

A public accounts committee is proscribed in what it can and cannot conclude about its ruling government. Even so, with so many glaring examples of wrong assumption, mis-matched expectations and calculation, the most compelling conclusion is perhaps the one it could not draw yet repeatedly points towards: the governing ideology and its strategy of austerity are causing the haemorrhage of good people from the NHS, and as trusts struggle to fill the holes they only widen.

This is at once both corrosive to the NHS and misinforming of its true nature and intent. Which is to undermine, fragment and privatise the NHS in the wrong belief that this "must be better". For whom? And how many good, well-trained and highly skilled people must leave the NHS before the folly of systematically cutting then privatising a health service is admitted to then addressed by those in power?

Alan Taman

Health Campaigns Together
Defending Our NHS ● www.healthcampaignstogether.com ● @nhscampaigns ● FREE

Update on Health Campaigns Together

Health Campaigns Together, the "coordinating agency representing all of the NHS campaigns" continues to grow and is starting to make its presence felt.

HCT's great strength lies in its ability to act as a unifying channel through which all of its membership organisations can achieve far more than they could hope to acting alone or in concert with one or two others.

This was demonstrated recently in the formation of an Advisory Group to meet with and advise Shadow Chancellor John McDonnell and Shadow Spokesperson for Health, Heidi Alexander. HCT was asked to put forward suggested areas for consultation, and to suggest named individuals to lead each specalised area, which in turn would reach out to the wider NHS campaigning community.

DFNHS member and Keep Our NHS Public Co-chair Tony O'Sullivan was asked to coordinate this, and in the end, after some deliberation, the Herculean task of coming up with 12 names and groups was agreed.

This is a substantial step forwards – not without risks of course – and promises to be the most direct channel yet to advise and influence the emerging Labour strategy on health over the coming 18 months.

John Lister is HCT's co-organiser (with Alan Taman) and sees great promise in its development:

> "I think what is critical to saving the NHS is to find ways of linking up the various different and often localised and fragmented campaigns to produce a common movement that can challenge the Tory cutbacks which are very substantial as a result of the freeze in real terms on health spending and the reducing share of GDP being spent on health in the UK since 2010, and as a result of the drive towards privatisation and fragmentation from the Lansley reforms.
>
> "That's what Health Campaigns Together sets out to do – to be a framework which can offer the opportunity for different organisations which can be informed and have otherwise quite different purposes to work together to build a movement that can challenge these aspects of government policy. What we want is something big enough to win victories, not simply to make points.
>
> "The idea is to make it into something with resources, enough to make campaigns really impact on the ministers and those making the decisions and try to change the course of history.
>
> "The junior doctors certainly give us grounds for hope, in that what we've seen on the picket lines and the meetings they've had where they've sent people along to the demonstrations they've organised themselves, is a new layer of radicalised junior doctors.
>
> "This is astounding in the context that historically this group has been the right-wing rump of the BMA; they have not been the most progressive element. They have been radicalised by what's been done to them by Jeremy Hunt, to the point where they don't just see this as a dispute around their particular issues of the unsafe, unfair contract but they also see that if they can actually win this one then they strike a blow to help defend the NHS as a whole and

prevent similar attacks on other sections of the NHS workforce.

"I think that is tremendously exciting and you don't often get movements like that of such significant numbers of professionals, particularly when they come from a history of being radicalised but in the wrong way!

"This has opened up a lot more discussion about how to fight back and what the issues are. It's astounding they've not only managed to carry their really powerful vote of their own organisation but they've managed to keep a majority of public opinion on their side despite the media coverage of their dispute being somewhat warped and despite having a series of quite controversial strikes. I think that's probably why the government was forced to re-open talks with them."

HCT's latest e-mail newsletter summarised the areas it had been active in:

Newspaper

"We have now published a second issue of our newspaper *Health Campaigns Together,* available in print as a tabloid, and free to access or download online. With enough support we hope to launch this as a quarterly, and possibly more frequent if there is enough interest to justify it. Please get your orders in at http://www.healthcampaignstogether.com/newspaper.php (price is per bundle per issue).

STPs and Footprints

"This issue has an update on the fresh massive top-down reorganistion being imposed upon the NHS in England with no political mandate or community support. The 44 'footprint' areas are supposed to draw up 1-year and 5-year plans – by the end of next month, to include plans to address local deficits and put struggling NHS and foundation trusts into financial balance.

It's already clear that this will mean a fresh offensive to 'reconfigure' and scale down hospital provision in many localities, based on specious and cynical claims that alternative services can be provided 'in the community', while public health, social care and community health services are all being cut back, and the evidence that many of the schemes can work at all is vanishingly small or non-existent.

We are urging local campaigns not only to take copies of the newspaper to spread the news we have, but to contact us at healthcampaignstogether@gmail.com with details of what's happening to health services in YOUR area and what campaigners are doing to fight back.

Some campaigners have now got together with 38 Degrees to launch a petition challenging the cutbacks from the STP plans. Please support it and share it widely:

https://you.38degrees.org.uk/petitions/stop-the-plans-to-dismantle-our-nhs

Junior doctors' dispute

"From the beginning HCT has been solidly behind the Junior Doctors in their battle to defend the safety of patients and staff and the quality of their training by resisting Jeremy Hunt's imposition of an unsafe and unfair contract.

Now we hear that the Junior Doctors' conference has adopted a motion which, along with urging the BMA to make stronger links with the trade union movement, also urges the JDC 'to lobby the BMA for it to consider joining Health Campaigns Together'.

We realise that this will be controversial with some doctors, and we cannot be sure what the outcome will be. We would obviously be honoured to welcome their support: but we will continue to support them, no matter what the outcome of this may be.

NHS bursaries

"HCT has supported the continuing campaign against Tory government plans to axe the bursaries that make it possible for many students to complete courses to qualify as nurses, therapists and other health professions.

Again there are links on our website, supporting the trade union and professional bodies' lobby of Parliament on May 25 and the Bursaries or Bust demonstration on June 4.

Fighting privatisation

"Following a Day of Action against Commercialistion and Privatisation of health care in Europe in April, the HCT website has now added a new section bringing together resources on fighting privatisation, and will have links to a new web resource being developed by the European Public Sector Unions (with 8 million members).

European Referendum

"As the Referendum date of June 23 draws closer, the TUC unions have responded to some of the concerns raised by public sector union members with an explanation of why the TUC is urging a vote to remain in the EU – while resisting treaties such as TTIP and CETA and their the imposition on health care.

The unions are concerned at the way in which the NHS is being used as an issue by the Leave campaign, notably by David Owen in the *Guardian* last month [1]. At the request of the TUC we have linked to their Briefing on the issue, while inviting HCT supporters to let us have their views. We have also added a link to the EPSU Briefing on CETA and TTIP.

Social care

"One concern that has emerged at our conference and in almost every discussion on the future of the NHS is the brutal central government cuts, and local government privatisation and fragmentation that have reduced Social Care to an inadequate minimal service, available in almost every area only to those with the most extreme needs.

A number of us are keen to investigate the possibility of launching a campaign for improved and expanded social care, under the wider banner of Health Campaigns Together.

We will report back on progress.

Local details

"Here's one more reminder: please keep us posted on your local issues and campaigns, if need be send us the complex plans and proposals you are struggling to analyse, and let's share information across our growing network. We need to celebrate your victories, learn from your mistakes and defeats, and build a movement strong enough to challenge governments.

With strong information on local campaigning, we can improve the newspaper and expand its circulation. Help us do that. Send your stories, ideas, cuttings, leaflets to johnlister@healthemergency.org.uk, or to Alan Taman at healthcampaignstogether@gmail.com and we can begin to put another issue together.

Donations

"Thank you to those individuals who have already sent donations to Health Campaigns Together online via http://www.healthcampaignstogether.com/joinus.php. We do need the funds. Online payments go straight into the account we are using."*

References

[1] Owen, D. (2016) 'Brexit is necessary to protect NHS from TTIP, says David Owen', *Guardian*, 6 April [online] Available at: http://www.theguardian.com/society/2016/apr/06/brexit-is-necessary-to-protect-nhs-from-ttip-says-david-owen

*Donations can be made online via the HCT website using PayPal, or please send cheques made payable to Health Campaigns Together, c/o 19 Northolt Grove, Great Barr, Birmingham B42 2JH.

Current Affairs

DFNHS main events since March

Doctors for the NHS was there to see parliamentary democracy at its most shameful. On March 11th the NHS Reinstatement Bill had its second reading in the House of Commons. This is a private member's bill, introduced by Caroline Lucas, but thanks to filibustering by the Tories she had only 17 minutes for her presentation. The whole parliamentary pantomime can be seen at (http://parliamentlive.tv/Event/Index/0aa3c938-4b3b-4911-9a80-c968b8f7ebe0) which includes excellent comments from DFNHS member Philippa Whitford.

There was a rally outside the House, lead by Tony O'Sullivan with contributions from David Owen, myself and other health activists. The NHS Bill if made law would abolish the purchaser-provider split and replace the machinery of the health market with public boards (more information at http://www.nhsbill2015.org/). Which will never happen while the Tories can muster enough highly paid, highly skilled people to talk about anything else at public expense. But it mattered and it still matters.

The NHS Bill remains a focus for the campaigning movement, and DFNHS continues to support it.

But hope lives. In April a group of campaigners met with John McDonnell and Heidi Alexander at the House of Commons, where we again encouraged her to support the NHS Bill; she again responded by saying this was too great a reorganisation and the public don't want another one.

I advised that we are seeing continual reorganisation and gradual destruction of the NHS anyway in the false name of "the market" and that reinstating the NHS could be done without disruption, citing the experiences in Scotland and New Zealand. Her reply was that it was easier for them because they were smaller countries, and then moved swiftly on to the next topic. Since then Rachael Maskell, MP for York and speaker at our last AGM, agreed to meet Allyson Pollock, DFNHS member and co-author of the NHS Bill, to discuss re-tabling the Bill in June, and a meeting has now been set up to take this forward.

At the April meeting John McDonnell suggested he met a small group of campaigners via Health Campaigns Together (see page 27) to be advisors on health issues on a regular basis. After some deliberation, HCT put forward a series of names, each of whom would be the leads for a given area of expertise (12 in total).

This includes DFNHS member Tony O'Sullivan, who was asked by HCT to continue as the principal organiser for the Advisory Group.

We recognise the pressures on GPs and we must support them, as one of the great strengths of the NHS has been the key role of the GP as the provider of most healthcare and their wisdom and commonsense in handling the rationing decisions required to prevent the specialist services from being overwhelmed. This letter will be sent to the GP press.

Terence Stephenson, chair of the GMC, announced in April that the junior doctors' strikes were "Increasingly hard to justify". DFNHS member and KONP president Wendy Savage wrote in the *Guardian* [1]:

> **"The GMC is traditionally apolitical and its strapline reads 'Working with doctors / Working for patients'. The estimated 24,500 cancelled operations over 4 months are regrettable, but the GMC has had nothing to say about the 18,000 elective operations cancelled at the last minute in the third quarter of 2015-16, before any strikes had taken place."**

We note the comments made by Terence Stephenson about doctors' duties and have written to him to request a meeting.

Reference

[1] Savage, W. (2016) *Guardian*, 19 April [online] Available at: http://www.theguardian.com/society/2016/apr/19/gmc-should-work-with-doctors-on-strike

Eric Watts
Editor
eric.watts4@btinternet.com

Twelve areas

The 12 areas of expertise advising Labour on its health policy agreed with Health Campaigns Together are:

- **Policy research (2 areas)**
- **Health campaigning research**
- **NHS Bill**
- **Clinicians (2 areas)**
- **Junior doctors**
- **NHS campaign: Keep Our NHS Public**
- **NHS campaign: 999 Call for the NHS**
- **NHS campaign: Momentum NHS**
- **Health associations**
- **Patients with long-term conditions**

Each area has its own lead, named individual, who in turn liaises with a broader sub-group with the relevant expertise. The Advisory Group is intended to meet quarterly.

Book Review

Handling the Media: Communication and presentation skills for healthcare professionals

John Illman. JIC Books (www.jicmedia.org) 184pp. £14.99

I think this book could be usefully read by all doctors, nurses and other health professionals who have to deal with the media and by medical journalists in training.

Handling the Media is an attractively designed and extremely well-written 184-page paperback. Its author, John Illman, is a very experienced medical journalist whose career included 5 years as a medical correspondent of the *Daily Mail*, 8 years as health editor of *The Guardian*, 3 years as medical correspondent on *The Observer* and founder editor of *New Psychiatry*.

The title of the book gives a very good idea of its content. It consists of 12 chapters such as Journalists; The news business; Responding to a media interview request; and Social media and blogging. Each chapter begins and ends with a neat summary.

Would the book help members of DFNHS liaise successfully with local and national media? I think the answer is definitely positive. For example, several chapters helpfully discuss different aspects of media interviews. John's wide experience shines throughout with practical tips.

Would the book help the reader overcome the widespread bias in newspapers against public services? The book doesn't discuss such bias – it is focused on the media as they are rather than how they might be if reformed, for example, along the lines advocated by the Campaign for Press and Broadcasting Freedom. A second edition of the book might well include a chapter on media bias.

Peter Draper

EXECUTIVE COMMITTEE : Elected at AGM 2015

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

Mrs A. Athow
General Surgery, London
0207 739 1908
07715028216
annaathow@btinternet.com

Dr M. Bernadt
General Adult Psychiatry, London
020 8670 7305
07510 317 039
mbernadt@hotmail.com

Dr C.A. Birt
Public Health Medicine, Liverpool
01422 378880
07768 267863
christopher.birt@virgin.net

Dr C.J. Burns-Cox
General Medicine, Bristol
01453 842243
chris.burns-cox@virgin.net

Dr J.R. Dare
Child Psychiatry, London
0208 297 2747
jr.dare@btinternet.com

Dr J.C. Davis
Radiology, London
0780 17218182
drjcdavis@hotmail.com

Dr M.G. Dunnigan
General Medicine, Glasgow
0141 339 6479
matthewdunnigan@aol.com

Dr P.W. Fisher (President)
General Medicine, Banbury
01295 750407
nhsca@pop3.poptel.org.uk

Dr A.R. Franks
Dermatology, Chester
0151 728 7303 (H)
01244 366431 (W)
Roger.Franks@btinternet.com
andrea.franks@nhs.net

Dr P.J. Hobday
General Practice
paul_hobday@btopenworld.com

Mr C.H. Hutchinson
Ophthalmology, Halifax
01422 366293
colinh759@gmail.com

Dr D.A. Lee
Paediatrics, Whitehaven
01946 820268
Lee535877@aol.com

Dr D.G. Lewis
Cardiac Anaesthesia, Leicester
0116 270 5889
geoffreylewis@outlook.com

Dr M. R. Noone (Secretary)
Microbiology, Darlington
01325 483453
malila@ntlworld.com

Dr S.A. Olczak
General Medicine, Boston, Lincs
saolczak@yahoo.com

Dr M. O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

Dr H.J. Pieper
General Practice, Ayr
hansandphil@icloud.com

Dr P.N. Trewby (Treasurer)
General Medicine/ Gastroenterology
Richmond, North Yorkshire
01748 824468
Peter@Trewby.fsnet.co.uk

Dr E.J. Watts (Chair)
Haematology, Brentwood, Essex
01277 211128
07876240529
eric.watts4@btinternet.com

Dr C.P. White
Paediatric Neurology, Swansea (Morriston Hospital)
CPWhite@phonecoop.coop

Dr D.G. Wrigley
General Practice, Carnforth
dgwrigley@doctors.org.uk

Dr P. M. Zinkin
Paediatrics, London
02076091005
pamzinkin@gmail.com

Communications Manager (paid staff)
Mr Alan Taman
07870 757309
healthjournos@gmail.com
aptaman@aol.com