DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

On the streets: The biggest NHS march ever

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MARCH 2017

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Published quarterly. Contributions welcome.

Facts Not Opinions; or Opinions Not Facts?

There is a yellow brick building in Southwark Street, near Bankside in London, that was the site of David Kirkaldy's Testing and Experimenting Works, built in 1874, to house machines to test iron and steel components used in boilers, engines, bridges and other buildings.

He was the first person to carry out tests on materials and components, to check their ability to perform their intended function, before they were assembled. Before that, it was a matter of trial and error. He received parts of the Tay Bridge, which had collapsed in 1880, and components of the Comet airliners that had crashed in 1954 were sent there.

The Works is still open to the public on certain days, and well worth a visit, but even the passer-by can see the motto of the founder carved above the door: "Facts Not Opinions"; a maxim that should have greater currency in today's world of fake news, alternative facts and influential, but shadowy, think-tanks.

One of the reasons that the practice of medicine is so fascinating, is that it encompasses so many aspects of human life. The variety of opinion is enormous and deeply coloured by personal experience, prejudice and political philosophy.

Opinions can, however, stimulate discussion and play a useful starting point for developing hypotheses which can then be tested. Many of us have the impression that there has been an erosion of professionalism, of job satisfaction and of enjoyment in the practice of medicine, that goes far beyond concerns over rates of pay and excessive working hours.

The relatively small, close-knit teams that used to be the foundation of clinical practice and teaching have been replaced by much more transient and diffuse arrangements, which can lack enough flexibility to bring trainees along at varying rates and give them personal support as needed. There were huge benefits in knowing the abilities and limitations of every person in the team, and how much could be safely delegated to them, and for the trainee to be comfortable in seeking support appropriately.

Loyalty to your colleagues in the team, and the patients under your care, were strong motivating forces. This newsletter contains the wide-ranging thoughts of Dr Arun Baksi and his colleagues on ways in which the benefits of such team working could be realised. They also explore ways of restoring greater levels of control over the working environment to front-line professionals.

Another aspect of our professionalism is explored by David Wrigley and Alan Taman, who consider the erosion of the ethical basis underpinning the NHS. It is inevitable that the "demand management" which forms a recurrent theme in STPs, will throw up very serious ethical questions for those doctors involved in developing and implementing STPs, but also for doctors and other professional staff working within such constraints.

Demand management essentially means reducing or denying access to treatment that would otherwise have been offered to a patient based on an assessment of the balance of risks and benefits to that individual. If, as some of us fear, the country is being softened up for the introduction of an insurance-based system of healthcare funding, the development of lists of exclusions limiting insurers' liability, and excess payments, would suggest that the process is in an advanced stage. Those of us who believe in universal and comprehensive access to healthcare need to fight such proposals at an early stage and make sure that the general public can see them for what they are.

There has been no shortage of opinion expressed this winter about the current state of the health and social care services in the UK and arguments about the contributing factors: political, economic, organisational, demographic, coming down to the human impact on patients, their families and the staff who work in these services,

captured by the BBC in its series "The Hospital". There have even been a few facts included, to prop up one or another side of the argument. Among these are the statistics published by the Health Foundation this winter, based on OECD figures for 2014, demonstrating graphically that the UK has many fewer doctors, nurses and hospital beds per 1000 population, and lower per capita spending on health than in those EU countries that we regard as our "competitors".

Two very interesting papers from Martin McKee and Danny Dorling's team are discussed later in this issue. They are based on facts: the startling official figures which show that mortality, which had been declining steadily for 40 years, levelled off in 2010 and is now on a rising trend and that life expectancy for the over 65s is decreasing.

These papers explore the statistics and possible explanations, but have been described by the Department of Health as "a triumph of personal bias over research", although they do not produce any reasoned argument for their denunciation and the official figures that would allow the next points on the graphs to be plotted have not yet been released.

No issue would be complete without a discussion of Sustainability and Transformation Plans, even though this should come with an apology to members living in the other parts of these islands, who are being spared this upheaval. The initial versions of these plans eventually saw the light of day a few months ago, albeit without the crucial appendices including the financial modelling, work-force planning and most of the detail that would make the plans anything other than a collection of aspirations.

We include a review of two papers on the STPs, one from the Centre for Health and the Public Interest, which has a strong track record of research based on sound evidence, and receives some financial support from DFNHS; the other is from The King's Fund, which tends to reach a different and larger audience.

It is interesting how they share many serious concerns with the plans and the process by which they are being drawn up, and that both flag up the absence of evidence to support the assumptions under-pinning many of these plans; maybe the STPs should carry the sub-title "Opinions Not Facts". We will need to wait and see whether either view can influence those who are hell-bent on taking us into uncharted waters.

In all the recent furore over health in the "national" media, little attention has been given to the fact that we have four different National Health Services operating in the UK. Although they are all directly affected by the unprecedented squeeze on funding from central government, and the disastrous (and intentional?) neglect of national work-force planning that has seen recruitment and retention issues destroying many local services, they do provide a laboratory to study the effects of different ways to deliver health care to our people.

Matthew Dunnigan gives us an intriguing update on the performance of the NHS and Social Care in Scotland, suggesting that the absence of the "market" has led to wiser investment of resources, better support for communities outside the cities and greater resilience than we are seeing south of the border.

The English media (apart from Channel 4 and the *Mirror*) were similarly happy to ignore the largest demonstration yet seen, of public concern about the handling of the NHS; this was organised by Health Campaigns Together (which includes DFNHS amongst its membership) and took place on 4th March in London. Our own Alan Taman was closely involved in organising the demo and had a ring-side seat; his report will hopefully encourage even more members to become involved in local and national groups and strengthen them with our professional support at this crucial moment, 99 years after the foundation of the NHS.

As Paul Hobday asked in December's Newsletter: "Where the hell are you and why aren't you doing SOMETHING?"

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Canary in the Coal-Mine?

Is the real "price of austerity" to be marked by an earlier grave for many?

There was a substantial increase in the number of deaths in England and Wales in 2015, when compared with previous years. This was noted throughout the year, but included a particularly sharp spike in January 2015. Should we be alarmed, or not?

What is certain is that we should be making every effort to identify the causative factors, particularly when there is evidence of a trend. These statistics have been subjected to closer analysis in two papers by Hiam, Dorling, Harrison and McKee, recently published in the *Journal of the Royal Society of Medicine* [1,2]. They show that the age-standardised death rate, which corrects for changes in the age-structure of the population, was steadily declining between 1980 and 2010, but then plateaued, and now seems to be rising, with 4.8% more deaths in 2015 than in the preceding year.

The figures show that this deterioration affected mainly the older population; if 2013 and 2015 were compared, there was a significant decrease in life-expectancy both at 65 and at 75 years of age.

They looked at the causes of death that were contributing to these changes in life-expectancy and found the dementias to have made the greatest impact. They make the point that the recording of causes of death in patients with multiple morbidities can be prone to bias and that the software package used to code deaths at the Office for National Statistics (ONS), was changed in January 2014, possibly leading to a 7% increase in attributing death to dementia.

There were also financial incentives put in place to encourage the identification of early cases of dementia in primary care between October 2014 and March 2015, which could have played some part in this apparent rise, so the authors urge caution in assigning too much weight to this association.

Given the particularly noticeable spike in deaths in January 2015, this was considered in detail – to see if data artefacts, cold weather or influenza might provide an explanation – and found little supporting evidence for these factors to have exerted a great influence.

The mean monthly temperature between September 2014 and January 2015 was above the 5-year average. The strain of influenza virus in circulation that year (A (H3N2)), is not a particularly lethal strain, but is thought to have a disproportionately severe effect on older people and the influenza vaccine that year was less effective than usual. There was also a particularly large proportion of outbreaks in care homes, with the potential to affect larger numbers of frail residents.

However, the recorded deaths attributed to influenza did not show a marked spike, and the pattern of increased deaths did not follow a course typical of influenza, remaining moderately elevated for several months after January, and there was no consistent evidence of similar effects in other European countries.

The increase in death rates since 2010, with a peak in January 2015, and no other obvious cause, does suggest that deterioration of the ability of health and social services to care for the frail elderly and respond to fluctuations in demand, needs to be considered as a cause. In 2016 the UK implemented changes to bring its health and social care spending in line with international accountancy practices. At a stroke, this suggested that the proportion of Gross Domestic Product (GDP) that the UK is spending on health had suddenly increased. This is reflected in the ONS health accounts for 2014 and the OECD health statistics for 2015, but this does not mean that there is a single penny more in the overall care system [3].

The changes have the effect of transferring very large amounts of money to "health" from the "social care" budget, such as the carer's allowance, and local authority funding for nursing and residential care. It does make it very difficult to compare levels of funding over the years, but even with these new conventions, funding for health as a proportion of GDP is less in the UK than in the Netherlands, Germany and France and flags up how poorly we support social care.

During the Coalition Government the number of elderly people with access to publicly funded social care fell by a quarter of a million. Local authority spending on social care for older people fell in real terms by 17%, while the number of people of 85 and over rose by 9% [4].

Local authorities have had to absorb massive reductions in the Revenue Support Grant, which is derived from general taxation, since 2010. My local authority will have had to make cuts of £100 million by 2020 – a 40% reduction in their budget, even including the Adult Social Care Precept that they can levy over the next 3 years. This Precept will yield much less to authorities where property prices are relatively low, such as the north of England, and in no way compensates for the reduction of the Revenue Support Grant.

The Coalition Government introduced the Better Care Fund, which recognised that it was irrational to consider health and social care in isolation, and removed money from the "ring-fenced" health budget to support the social care funding of Local Authorities. Even when this is added to the sums raised by the Social Care Precept, the share of GDP spent on social care will have fallen from its 2009 level of 1.2% to 0.9% by 2020 [5].

The National Audit Office report in February 2017 has noted that the first year of the Fund did not produce the financial savings anticipated, and delayed transfers of care and emergency admissions to hospital increased, rather than showing the fall that they had predicted [6]. Obviously, it is early days, but the National Audit Office raises concerns about over-optimistic estimates of financial savings, and unrealistic time-scales required to integrate health and social care. They also draw attention to the lack of involvement of most local authorities in drawing up Sustainability and Transformation Plans and the use of Transformation Funds to plug deficits in the budgets of acute providers, leaving very little for actual transformation (or even essential maintenance of buildings or equipment).

> "There is ample evidence accumulating, that our public services have been deteriorating rapidly and a dearth of evidence to support many of the policies that are being pursued."

The Care Quality Commission has reported the seriousness of the situation in its latest report [7]. It points to the fragility of the market in care homes, and particularly in nursing homes, due to a reduction of 9% per person in real terms in the levels of funding from Local Authorities.

This is leading to the closure of many small and medium-sized homes because of a combination of staff shortages and narrow profit margins. Between 2010 and 2015 there was a reduction of 8% in numbers of care home beds. Nursing home beds increased by 9%, but have shown no further increase since March 2015.

Other aspects of primary and community care are struggling, with a reduction of 28% of full-time-equivalent District Nurses between 2009 and 2014 [8] and a sharp fall in the number of full-time-equivalent General Practitioners [9], with nearly one-third of GP partners in England being unable to fill vacant posts for more than 12 months during 2016 [10].

Unsurprisingly, in 2016, there had been a

marked increase in patients whose discharge from hospital had been delayed [7] and the main cause was the rapid increase in people waiting for care packages to be set up to allow them to return to their own homes, and those awaiting placement in a nursing home. Now we don't just have increasing waiting times for people to get into hospital, but lengthening waiting lists to get out.

When so many components of the care system are operating at the limit of their capacity, it does not take much additional demand to tip them into crisis. Is this what happened in January 2015? Hiam et al. noted a marked deterioration in performance standards during that month: all ambulance response times fell below target; numbers of patients waiting over 12 hours to be admitted from A&E increased enormously, even though A&E attendances showed no overall increase; operations cancelled for non-clinical reasons; delayed transfers of care; waiting times for consultant-led care and for diagnostic tests. The picture could bear many similarities to that in January 2017.

It is sobering to see the break in the downward trend of age-standardised mortality rates after 2010 in the first of these papers [1]. It will be extremely interesting to see whether the reduction of life-expectancy continues. The figures for death rates for 2016 have a provisional date for release in July-August 2017. The authors have commented on the severe disruption to the operation of the Office for National Statistics as a consequence of its recent move from London to Newport, with its associated loss of key staff and institutional memory, which has been blamed for the reduced quality of UK trade statistics. When alternative facts and fake news are such a threat to good government, and to peoples' confidence in their elected representatives, accurate statistics need to be a national priority.

The authors of these two papers admit that they have presented "an exploratory analysis of a complex phenomenon", but hope that it will stimulate debate and further scrutiny. We should all be joining with them in asking why the search for a cause is not being pursued with more urgency. Facts may be inconvenient, but it is irresponsible to neglect to investigate the underlying causes because of fear of what you might find.

There is ample evidence accumulating, that our public services have been deteriorating rapidly and a dearth of evidence to support many of the policies that are being pursued. If the canary is lying at the bottom of its cage in extremis, we need to get back to a place of safety: what we can't afford to do is to assume that it is just taking a rest. We need to make sure our national and local policy-makers understand the consequences of their actions, and are held to account for them, and stop breaking our care services on the wheel of austerity.

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Deathly Gradient

It is not only the increase in mortality that gives grounds for fury. The differences in mortality across geographical and socio-economic groups show a worsening picture, reflecting increasing inequality.

A point expertly made by Micheal Marmot in *The Health Gap: The Challenge of an Unequal World* (Bloomsbury, 2015), in which the soaring differences in ill health, mortality and achievement through life are mapped out across the UK, and the causes of them meticulously explored, leading to one overriding conclusion: poverty, disempowerment, lack of education and life-long denial of equal opportunity will have remorseless effects not only on what someone is likely to achieve in life, but on how healthy they are likely to remain and on how long they are likely to be with us.

Richard Wilkinson and Kate Pickett drew much the same conclusion – that equality is in fact better for everyone – in their ground-breaking *The Spirit Level* (Penguin, 2010) which looks at all the effects of inequality and focuses on physical health and life expectancy in Chapter 6. Chillingly, towards the end we read "The dramatic changes in income difference in Britain during the two world wars were followed by rapid improvements in life expectancy"; it should give no one any comfort to see the complete antithesis of that observation playing out today, as "austerity" sends many needlessly to an early grave.

Sustainability and Transformation Plans under the Spotlight

The Sustainability and Transformation Plans: A Critical Assessment
by John Lister. CHPI: London
Delivering Sustainability and Transformation Plans, from Ambitious Proposals to Credible Plans
by The King's Fund: London

Now that Sustainability and Transformation Plans (STPs) have been published for all 44 'footprints' covering England, the last few weeks have seen two reviews of the plans, coming from two different perspectives, which allows some interesting comparisons.

John Lister, the co-founder of Health Campaigns Together, which is campaigning against the STP process, is the author of *The Sustainability and Transformation Plans: A Critical Assessment* [1], published by the Centre for Health and the Public Interest (CHPI). CHPI has an excellent track record of publications centred on independent research founded on evidence of high quality.

In contrast, the King's Fund has been broadly supportive of the concept of STPs and the direction that they set. Their latest report *Delivering Sustainability and Transformation Plans, from Ambitious Proposals to Credible Plans* [2], does highlight the difficult road that these plans face if they are to be translated into some form of reality, and is critical of the way in which the process is being handled, while suggesting how they might make some progress given the constrained financial circumstances in health and social care.

The King's Fund report begins with a description of how the NHS has adapted to changing circumstances through its history, and then a long section illustrating many of the common themes appearing in the thousands of pages of the plan documents. This section retains the peculiar language of the original documents with lots of positive words which add up to very little substance, and probably will not tell you much you don't already know if you have had the stamina to read through one STP in its entirety. Sections 3 and 4 are much more interesting.

Section 3 applies critical analysis to the themes running through these plans, and there is a surprising degree of agreement with John Lister's critique. Both reports decry the lack of involvement of many front-line clinical staff and the general public in the planning process so far. The King's Fund feel that this is a consequence of trying to bring together so many organisations that have never worked together before, and indeed, may have been in competition, to draw up ambitious plans, in a time-frame that fits with political schedules.

When one of the principal ambitions has been to develop strong links between health and social care, these factors have contributed to a very variable and limited degree of involvement of local government in what seems to be a health-dominated process. The published plans are full of jargon and technical language; and even where plain English is used, the language is designed to mislead, using words like "integration" and "self-care" to distract from unpopular changes and service reductions. It will require a huge effort to make up lost ground and engage in real consultation. [*See Gill George's remarks about this in the report on the 4 March 'It's Our NHS' demonstration, page 14.*]

Both reviews criticise the lack of evidence to support the premises upon which some of the most controversial changes are based and the way in which the appendices that contain

such vital details as the financial and work-force modelling have not been published for most plans, making it difficult to assess whether these are real plans, or just aspirations. John Lister details the evidence that community and home-based care actually costs more to provide than hospital-based care if it is extended to more seriously ill patients, and yet this is a driving force behind many recommendations in these plans. The King's Fund have reported that reconfiguration of hospital services to concentrate some services in fewer hospitals can improve the quality of care in some services, such as major trauma, vascular services and stroke care, but that evidence of financial savings are almost entirely lacking [3].

Both reviews stress that workforce shortages are as much of a limiting factor as financial shortages in achieving a move of care from hospital to community. The reduction of 40% in the District Nursing workforce over the past 20 years and serious recruitment and retention problems in general practice are particular barriers to these plans, but they lack any workforce planning detail. Most plans seem to shrink the service to match the staff available rather than supporting a sustained drive to train, recruit and retain the staff required for a safe and efficient service. Some plans do refer to an increasing role for new kinds of staff – including Nurse Associates, to support Registered Nurses, and Physician Associates, to support medical staff – but this is yet another experimental aspect of the plans, where supporting evidence does not exist.

The King's Fund see the vanguard trials of new models of care in the community, particularly accountable care organisations, as being the best opportunity to strengthen the integration of all groups of staff working in the community and across the boundaries with acute hospitals and social care. The belief is that this will make most efficient use of staff and resources and reduce reliance on acute hospitals, but they stress the overwhelming need to increase funding for social care and ring-fenced funding to allow double running of acute hospital services while these new models of care are being developed.

John Lister is much more sceptical about the potential for accountable care organisations to improve services at the same time as saving money, and points out that these organisations in the USA receive allocations between 3 and 5 times greater than the average health spending of £2057 per head of population currently allocated in England, which is set to fall over the next 3 years [4].

"Most plans seem to shrink the service to match the staff available rather than supporting a sustained drive to train, recruit and retain the staff required for a safe and efficient service."

Neither review speculates on the concern of many activists that accountable care organisations would fit neatly with an insurance-based system of funding for the NHS and may play the part of a Trojan horse in a long-term strategy to dismantle the NHS.

Although the King's Fund note that many STPs have plans to greatly increase the use of information technology, they do not reflect critically upon this, presumably because there is so much uncertainty as to which systems improve efficiency of clinical staff, and which are costly mistakes.

John Lister points out that the idea that large investments in digital technology can realise significant savings is without evidence. The frail elderly, often living in isolation, are often those most in need of care, but the least likely to be able to use apps for self-care and e-consultations.

Similarly, many of us have experienced the introduction of IT systems that are so time

consuming and frustrating to use that they reduce the efficiency of staff. In my own practice, an electronic document archiving system cut the number of patients that could be seen in a clinic by 30%, while dangerously reducing the ability to retrieve essential clinical information.

The King's Fund points out that STPs have no basis in law, being a way to circumvent the organisational chaos caused by the Health and Social Care Act 2012. This leaves their decisions open to challenge through judicial review, which could prevent or delay the implementation of some aspects of the plans (see [5] for further discussion).

The Act and its associated legislation also requires consideration of patient choice and commercial competition, raising the possibility of referral of service changes to the Competition and Markets Authority, with resulting delays and risk of rejections. (Activists should bear this in mind when considering challenges to some of these plans.) They recommend review of the 2012 Act to give a statutory basis to STPs and their relationship to boards of NHS organisations and local authorities and to consider changes to the emphasis on choice and competition.

Whether the government has any stomach to revisit the Act is another matter.

Section 4 of the King's Fund report suggests a way to take these plans forward in a modified fashion, given that almost all of the capital funding required to support their roll-out has been diverted to mitigate the revenue consequences of the increasing under-funding of acute trusts. They feel that the STPs need to focus on those proposals that offer most potential for improving care while also reducing the financial gap in the budgets of health and social care and which can work within the known constraints of funding and workforce availability.

Many of the proposed hospital reconfiguration schemes will not be able to take place and they are certain that extreme caution should be exercised in any further reduction of capacity in the hospital sector until strengthened community services are in place.

They see the building up of capacity in community services, to provide alternatives to hospital care, as the highest priority. The King's Fund feels that the pilots of new care models are already making a difference in reducing the demand for hospital care, although transformative changes take time to deliver measurable benefits. These schemes now need to produce the data that can demonstrate this impact and which they feel is necessary to convince the government to release the funding to unlock their full potential.

Although the crucial role of prevention of ill-health in the long-term moderation of demands for hospital services was emphasised in the *Five Year Forward View*, the STPs pay little more than lip service to its importance, with hardly any detailed programmes of health promotion. This is because the return on investment in such schemes is too long term to fit with the political cycle. The situation is aggravated by the savage reduction in funding of Public Health in England in the Comprehensive Spending Review 2016. The King's Fund stress that preventive measures should instead rank as the second highest priority and require a much clearer focus.

The priorities established by the King's Fund, with the emphasis on improving community services and prevention of ill-health, are radically different from those in most of the current STPs and they warn against plans that concentrate on further reducing capacity in acute and community hospitals:

"Work under way to test the assumptions on which STPs are based should test rigorously any proposals to reduce hospital capacity – if necessary to destruction."

They also make the point that the government needs to get behind such revised plans, with appropriate and ring-fenced increases of funding, a realistic time-scale for delivery, long-term commitment and the legislative changes required.

John Lister describes the alternative scenario that would arise if we just continue on the current course outlined in the published STPs, in which case lack of funding would lead to a downward spiral of hospital and service closures, without robust services in the community to moderate demand for care and the real risk that the NHS will collapse: "STPs cannot solve the problem of inadequate funding."

Both reviews are in agreement that the plans in their current form will not achieve their stated aims, in the prevailing climate of austerity and workforce shortages. Both agree that reducing hospital services would be extremely hazardous and that the unrealistic timescale that is being imposed is resulting in almost total neglect of public health and other measures to deal with the socio-economic causes of ill health, which misses the very real opportunity to reduce the burden of disease in the medium to long term.

Where they differ is that the King's Fund feel that substantial changes to the plans and the implementation process could have a positive impact and be compatible with the survival of the NHS, while the Centre for Health and the Public Interest feel that they are, at best, a distraction and risk hastening the demise of a service that has contributed so much to the quality of life in this country.

In the words of Simon Stevens, these plans are the only game in town, but many doctors are only vaguely aware of them, and even fewer have been involved in the planning process. They represent the biggest restructuring of health services (and social care?) in the history of the NHS, so we all need to understand them in as much detail as possible.

Plough your way through the plan relating to your own area, then read both these reviews in full. You will then be in a good position to make your own judgment as to whether to give them a qualified welcome, or your outright opposition, and to contribute to the debate.

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It's Our NHS

The NHS march and rally on 4 March drew at least 200,000 people into London, from all parts of the country. This photo shows the street outside the BMA full with marchers. The crowd filled the entire square and surrounding streets. Parliament Square, the end of the march, could not hold them all.

Gathering Pace: 4 March NHS Rally Report

The day was a sea of colour, clamour and song. People from all over the country, of all ages, from all backgrounds, chanting, shouting, walking and singing with but one purpose: to tell everyone that the NHS belonged to all of us and was being pulled apart by a government that placed ideology above all else.

John Lister's opening speech at Tavistock Square made the point that the march was a declaration from all over the UK.

"This march alone won't get us where we need to be. It's a beginning. Don't go home and do nothing, go home and organise. We can beat these people."

John was followed by 14 other speakers, all of them rallying the crowd. These included **Dr Gurj Sandhu,** Emergency Consultant, who said:

"In a world full of fake news and alternative facts, let me give you some truths from the front line about the NHS. Emergency Departments are at crisis point. There is no horizontal space left for doctors to examine patients.

"In this wonderful capital city of ours, we have run out of beds to look after our sickest children. Yet junior doctors and nurses every day perform miracles to keep people safe. Social care is at crisis point. The system is saturated to the point where we cannot get people out into the community.

"Despite these miracles people are dying. It is a well-established fact that austerity kills. In 2018-19 in real terms, NHS funding is going down."

The most entertaining "act" of the morning was probably **Dr Phil Hammond,** who got the crowd chanting several memorable phrases, such as "The NHS isn't over-spent, it's under-funded by 20 per cent!".

No one should doubt the power of that; advertisers have been tapping it for decades. Every little helps…

Lesley Page, from the Royal College of Midwives, said that: "midwives are there for the birth of our babies. They are the enablers of the birth of our future. As we march today, let's stay united and let us re-double our efforts to fight, fight and fight again the NHS that we all love."

Lesley was followed by **Larry Sanders**, brother of US Democrat socialist Bernie and spokesman for the Green Party for health, who put it simply:

"Last week there were dozens of meetings like this in America because the despicable Trump is trying to throw 20 million Americans out of health care. If we don't fight to save the NHS, the whole left wing in this country is finished.

"For 50 years the average age of death has gone up. What happened last year after 6 years of cuts in health care and social care? It turned. For the first time, the average age is lower. That is a sign. That is what we are up against."

Gill George, from Shropshire Defend Our NHS, brought waves of laughter when she read out choice phrases from her own area's STP, which included:

"We are going to have the healthiest population on the planet in Shropshire. I know that because I've been reading our STP! We are going to 'embrace the specific paradigm of wellness'. We are going to develop 'a single shared view of the place-based needs of the population using advanced business intelligence capabilities'. Well what nonsense.

"Our position in Shropshire is that we fought back. We stopped savage cuts to services…. Fighting

back does not guarantee victory but it's much better than sitting back and waiting to see what happens."

To say the march to Parliament Square was successful would be to understate its sheer size. Many could not even get into the Square, and were still marching when the speeches began.

The rally at Parliament Square, where DFNHS and Save Lewisham Campaign member Dr Louise Irvine was the compère, had an equally impressive range of speakers, and almost certainly a much bigger crowd.

Dr Aislinn Macklin Doherty, from the Junior Doctors Alliance, appeared in front of the crowd in her white coat and said:

"I am used to treating people based on what they need and not what an insurance company thinks they are worth. There are not many doctors in the world who are lucky enough to say that. And I'm worried that I won't be able to say that much longer.

"There have been a tidal wave of private companies taking over your NHS from the inside, misreported and spun as a good thing when this leads to higher costs and poorer quality care and must be resisted. If we all act together we can change things and reinstate the NHS back to its original principles."

DFNHS member and Keep Our NHS Public Co-Chair **Dr Tony O'Sullivan**:

"We in the NHS achieved real integrated care with other agencies. Our skill and commitment in the staff working together with patients. We don't need Simon Stevens or STPs to tell us what reconfiguration means. Now in Keep Our NHS Public the fight is on to save the very services those families I've worked with for 25 years rely on. This government is ideologically opposed to funding public services. It is disintegrating the NHS and social care. Where private companies may profit from our suffering.

"Our principle is that we must unite on what we agree on. The only value of coming here today is if we go away determined to join in the battle to save our NHS and social care."

The "headline act" was undoubtedly **Jeremy Corbyn**, who said:

"Without the NHS being properly funded we would not be a civilised country. Anyone who dilutes it has literally no morality.

"The Tories cut taxes on big business. Don't let them tell you there is no money for the NHS. The money is there.

"Think for a moment for every student nurse forced to go to a food bank as they care for people. One of those things that has come about from a political choice made by a government that underfunds the NHS and social care when they know full well the resources are there to do it.

"They say tax cuts are more important than dignity. I say let's support and value our NHS staff.

"The NHS was created by people with vision. The idea that healthcare should be free at the point of use and a human right. Our NHS is not for sale. It's ours, for everybody in this country to keep.

"You know how strong our endeavour, our determination, our principles are. Defend the NHS with all your might."

Keith Venables, Acting Chair of Health Campaigns Together and Co-chair of KONP, wound up the speeches at the end of what was a momentous day for anyone who was there.

Was it effective? I can tell you we made a difference. The sense of solidarity and affirmation of anyone who was there are all the stronger for it. By police estimates, at least *200,000* people turned up on that day for the NHS.

We don't yet know if we are winning but we are uniting. And if this government will not listen, we will not be stilled. It is our NHS.

Give it back.

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DFNHS Chair Eric Watts remonstrates with a professional rival (top); Opposition leader Jeremy Corbyn MP addresses the crowd at Parliament Square (right); and DFNHS EC member and this issue's Editor Colin Hutchinson marches with his wife Annemarie, suitably attired (below).

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What has devolution meant for the NHS in Scotland?

The devolution of healthcare to Scotland (together with Wales and Northern Ireland), created a case-control study in which a public sector model of healthcare, based on integration and cooperation among its component parts, could be compared with an increasingly neoliberal public sector health model in NHS England based on competition between healthcare providers, increased choice for consumers (patients) and increased opportunities for private sector providers to compete for NHS funding.

There have been few detailed analyses of the relative effectiveness of the Scottish and English systems in meeting the rising demand for both emergency and elective healthcare.

In 2010, the Nuffield Trust produced a report comparing the relative performance of NHS Scotland and England between 1996-97 and 2006-07 [1]. The authors interpreted more rapid increases in inpatient and day case hospitalisation rates and in outpatient attendance rates in NHS England, compared with NHS Scotland, as evidence of significantly increased English productivity driven by market-oriented reforms.

But as noted in previous NHSCA newsletters in June 2011, 2012, 2014 and September 2013, subsequent analysis and deconstruction of these trends by the author between 1998-99 and 2010-11 showed that the differences were more apparent than real.

Some resulted from the perverse incentives introduced by Payment by Results (PbR) to NHS England in 2004, with increased recording of inpatient, day-case and new outpatient activity. In NHS Scotland, contrary trends resulted from more rapid transfers of inpatients to day-case settings, of elective day-case to outpatient settings, and of a rapid increase in nurse-led clinics for many routine endoscopic procedures.

NHS Scotland also implemented a policy of integrating social and NHS care. A further component of the healthcare model has been the development of Managed Clinical Networks. These have enhanced the viability and sustainability of Scotland's district general hospitals, particularly smaller hospitals in remote areas which can readily refer patients for further treatment and investigation to other secondary and tertiary facilities.

In other respects, comparisons of a wide range of performance indicators showed similar rapid improvement in both NHS Scotland and England between 1998-99 and 2010-11, with comparable improvements in public approval ratings of NHS performance. These striking improvements were confirmed by a revised Nuffield Trust report, issued in April 2014 [2].

One disadvantage of the focus on organisational change has been to under-estimate the crucial role of the huge increase in capital and revenue expenditure by the Labour administration between 1998-99 and 2010-11, transforming the performance of the NHS.

Per capita health expenditure in NHS England and Scotland over this period increased by 98% and 78% respectively in real terms. This financed large increases in medical and nurse staffing and initiatives to reduce waiting times and lists. Large increases in capital expenditure permitted an extensive programme of new hospital building, albeit mainly through the wasteful Private Finance Initiative.

This period of rapid improvement in NHS performance came to an end following the 2008 financial crash, the subsequent election

of the Coalition administration in 2010 and the initiation of an unprecedented period of austerity.

This raises the question of whether the neoliberal market model of NHS care being implemented in NHS England in the face of austerity is more or less resilient than the public sector model operating in Scotland.

In 2010-11, despite having only 8% more health spending per capita than NHS England (£2,089 vs £1,932), NHS Scotland employed 19% more doctors, 27% more GPs and 31% more qualified nurses per capita than NHS England. In that year, Scotland had 48% more acute staffed beds and 81% more staffed beds in all specialties per capita than NHS England.

This suggests that NHS Scotland may have distributed its NHS revenue more judiciously than NHS England and obtained better value for money.

NHS England and Scotland: 2010-11 to 2015-16

The dominant factor in deteriorating performance since the election of the Coalition government in 2010 has been the largest reduction in NHS expenditure since the Churchill/Eden administration (1951-55). The Institute of Fiscal Studies (IFS) estimated that between 2009-10 and 2015-16, planned health spending in NHS England and Scotland would rise by 4.4% and fall by 1.2% respectively in real terms. Since NHS (HCHS) inflation is higher than general (GDP) inflation, these estimates imply a reduction in NHS expenditure in real terms in both health economies.

The impact of reduced funding became fully apparent in 2014 and 2015 in both NHS England and Scotland, with the return of prolonged delays in A&E units, rising numbers of cancelled elective admissions, longer waiting times for elective admissions and rising levels of bed occupancy, aggravated by increasing numbers of delayed discharges. The Institute of Fiscal Studies projected reductions in overall public

sector spending of 13% and 8.4% in England and Scotland respectively between 2009-10 and 2015-16, leading to reductions in long term institutional and supported home care capacity in England and Scotland.

The return of severe pressures on NHS and community healthcare capacity provides clear evidence for the dominant role of funding in determining improving NHS performance in the face of rising demand.

In NHS England, financially independent foundation hospital trusts deriving a large part of their revenue from a complex Payment by Results (PbR) tariff appear increasingly unstable in the face of falling revenue. Many are in financial deficit and several are being broken up and recombined with other trusts on financial grounds.

In contrast, since the abolition of the internal market in healthcare in 2003, hospitals in NHS Scotland have retained organisational stability. Despite reductions in funding as in NHS England, there are no financially failing hospitals since they are funded centrally by a resource allocation formula which includes caseload only as one indicator of relative need.

In the four UK health economies, the combination of rising demand and falling NHS revenue over the 2016-17 winter months has resulted in an unprecedented fall in the attainment of performance targets. A recent survey by BBC News on 6th February 2017 found that NHS Scotland's hospitals performed best of the four economies over this period,

possibly because of the progressive integration of NHS and social care and the greater per capita provision of NHS medical and nursing staff and staffed hospital beds than in NHS England as noted above.

The results of the present study are supported by Maynard who recently concluded that the internal market in healthcare is neither effective nor cost-effective, providing fragmented primary, secondary and social care with escalating regulatory costs.

In implicit recognition of this critique, NHS England is implementing a new planning regime with a "fundamental change of direction".

The 5-year Sustainability and Transformation Plan (STP) lays increasing emphasis on "collaboration and joined-up services" and less emphasis on organisational separation and autonomy. Details of the proposed structure and organisation of the 44 STPs to be established in NHS England are not currently available, but appear to involve further substantial reductions in staffed beds.

This further reorganisation will not reverse the decline in the performance of NHS England in the absence of a substantial reversal of the unprecedented reduction in NHS and social care funding since 2010-11.

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FOR THE NHS NOT PROFIT

A New Model for the NHS in England?

"Oh no, not *another* reorganisation idea?" might be your initial response. But it is widely agreed that the only way we are going to stop the breaking up of the NHS in England will be to dismantle the innately self-destructive internal market, and all that means for NHS structure, working relationships, and the terms and conditions of NHS staff. Currently under siege daily from the nefarious effects of the Health and Social Care Act, STPs, and all that flow from them.

EC member Arun Baksi is proposing a model to achieve this. Over the following pages, he and his colleagues outline what they mean. Of course there are weaknesses – there always are. But if we are going to get the NHS to survive, models like this one must be considered properly.

Common Sense Solutions to Some of the Problems in the NHS

It is our firm belief that the NHS has been underfunded for many years, a situation made worse because of serious lack of funds for social services and public health; the inadequate social services greatly impinge on the functions of the NHS. However, there are other major issues which are growing insidiously but rapidly, and they require urgent attention.

We present solutions to these issues that will require very little expense or none to implement. We are also aware that some of the solutions we recommend will require parliamentary intervention; these are presented separately. Whilst we continue to seek more funds, it is perhaps even more important to consider how we could reduce daily wastage of funds.

What are the problems?

- Low morale, lack of appreciation and not being valued, destruction of teams within hospitals, loss of belonging, fear and bullying, which is usually quite subtle but can be explicit.
- Staff are ignored by management, not consulted about changes that are required.
- Absence of a visibly independent person who could be trusted to hear complaints and short comings.
- Lack of accountability, lack of transparency and secrecy in planning, little encouragement for innovation, lack of understanding and trust between management and staff and inappropriate use of trained and untrained staff.
- Cancelled operations, lack of beds, stretched Emergency Departments, failure to provide 24/7 diagnostic services, frequent transfer of patients, lack of care facilities for the frail and elderly.
- Reduced and inappropriate training, lack of flexible working, no effort to retain staff, no reward for hard working staff, and no effort to measure productivity.
- Management excesses, use of management consultants, outsourcing services, sale of assets, too many line managers.
- Loss of vocational ethos, lack of leadership at all levels.
- Lack of holistic approach, district hospitals are increasingly specialised.
- Crisis in general practice services, and inadequate public education about NHS.
- Areas of wastage – Waiting list initiatives, creation of provider and purchaser system, wastage of supplies and packaging, use of locums, complete lack of uniformity in IT provisions, inadequate data management, failure to charge non-residents, PFI, use of independent providers, and frequent changes in the NHS structure without any evidence supporting these changes.

In the sections that follow, we discuss these and our proposed solutions to them.

A national conference

It is our intention to hold a national conference to air our solutions. There are many people who share our views, and the purpose of holding a national meeting is to draw the attention of people who matter and to start a movement to promote ideas similar to those outlined here.

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Solution 1: Establish ward based teams

1. The ward sister should have total control of all aspects in the day-to-day functions of the ward.
2. The ward sister should be directly responsible to the Director of nursing; there should be no intervening line manager for this function.
3. All non-medical staff whose role encompasses working directly with patients on that ward or only with medical or nursing staff on that ward should be answerable to the ward sister.
4. Each ward will have a dedicated number of senior and training grade doctors, each of whom will be answerable to the Medical Director. The number of such staff will be dependent on the size of the specialty.
5. All meetings with senior management will be recorded, and minutes held by the ward sister.
6. All clinicians of the ward will be collectively responsible for the medical care of patients in the unit.
7. Transfer of patients to other units should cease unless it is required for the management of the patient's clinical condition.
8. The ward sister shall hold regular team meetings.
9. Each unit will regularly publish data pertaining to quality and productivity.

Benefits from this change

1. It will immediately provide much improved continuity of care.
2. Patients and their relatives will know the identities of health professionals providing care.
3. Patient experience will be much enhanced because of not being moved around different wards.
4. It will considerably increase quality of care out of hours.
5. Health professionals will experience enhanced work satisfaction because of the ability to provide continuity of care.
6. This will result in improved sense of belonging, identity and being valued. This will result in significant improvement of morale throughout the hospital.
7. Accountability will be established not only at the unit level but also encourage management to accept responsibility; minutes of meetings will assist this.
8. Each unit will be encouraged to think of innovative ideas to improve care and will lead to the development of visible leaders.
9. The regular publication of data from each unit will result in an open, learning environment, which can only lead to continuous improved quality of care throughput the hospital.
10. Each unit will be able to assess appropriate continuing education for the workforce.
11. Flexible working will be assisted.
12. This change alone will greatly improve morale, and enable staff to give its best out of a sense of belonging to a caring team. This will also result in reductions in the number of staff on sick leave, and will go a long way to retaining staff.

Solution 2: Ring fence surgical beds; blocked beds; inefficient Emergency Departments

Why?

The main reason for "delayed discharges" (blocked beds) is the large number of elderly and frail individuals who no longer require any medical care but cannot be returned home safely because of a serious lack of care facilities within the community. The continued unsupportable closure of hospital beds has largely contributed to this situation. It is difficult to understand the logic of bed closures when social services have not kept pace with the increased needs within the community.

Solution

1. It is therefore proposed that hospital beds should not be reduced until adequate facilities have been established within the community.
2. Blocked beds are almost the only reason for the repeated cancellation of surgical lists, giving rise to continued suffering of patients and increased frustration of patients and staff. Surgical beds should be ring fenced.
3. Ring fencing surgical beds makes it imperative that we create "half-way homes" to accommodate those patients who are ready for discharge from hospital.
4. To convert closed wards into half-way homes that will provide social support and not medical care. Such units will be staffed by suitably trained individuals to provide supportive care, and be supervised by an administrator. Although such beds will be within the hospital, they will be the responsibility of social services.
5. Whenever closed beds have been opened to ease blocked beds, they have invariably been staffed and run like a hospital ward thereby making the change just as expensive, unnecessarily.
6. Urgently negotiate with rest homes and hotels to be converted into half-way homes, again under the auspices of social services.
7. Explore creating half-way homes near general practice units.
8. The safety requirements of such homes should be pragmatic and be easy to inspect. It is important that society does not insist on utopian standards; at such homes members of the family and friends will be encouraged to share the caring role.
9. Use of day care facilities should be explored. Such a provision will enable family members to continue working whilst sharing the caring tasks for the rest of the day.
10. Failure to make a diagnosis results in delay in treatment that then determines the length of stay. Diagnosis often requires the availability of a prompt diagnostic services at all times. The lack of the latter facility out of hours is largely responsible for some inappropriate treatments and delayed confirmation of diagnosis. There is an urgent need to ensure that diagnostic services are available 24 hours each day.

Benefits

1. Operations lists will be at much lower risk of being cancelled.

2. Patients will no longer have to suffer unnecessary pain and frustration.
3. Staff will no longer be frustrated and morale will rise.
4. There will no longer be any need to send patients to other hospitals.
5. Extra lists will not be required.
6. The hospital will save money.
7. This may encourage social services and local authorities to think of new ways to cope with increased demands.
8. The full effects of these changes will be multiplied by our "ED Model" (see next section).

Solution 3: New Model for Emergency and Acute Admissions in District General Hospitals

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Introduction

Although the current emergency care model is practical and meets the training requirements of the royal colleges while striving to meet the targets, there are a significant number of occasions where the system has struggled to achieve the desired efficiency.

1. *Under staffing:* To maintain or recruit sufficient number of middle grade ED doctors remains a problem. With the proposed locum pay cap, it is going to be even more difficult to get additional help to fill the rota gaps.
2. *Duplication of work:* Following triage, a patient is reviewed by an ED doctor who then makes the decision whether to admit the patient. When the decision is made to admit, the ED doctor then refers the patient to specialty team for ongoing investigations and management. In the majority of the hospital, specialty teams re-clerk the patient with only minimal added information.

This above process invariably leads to increased ED waiting times and lack of timely assessment by the specialty teams, particularly at peak times. We propose a new model to address the above issues.

The proposal

There should be an integrated approach to the ED which blurs the line between ED and specialty on-call teams.

The first and most important step in the proposed model is "robust triage". A senior nurse or ED consultant/middle-grade should be involved in allocating patients to different "zones" according to the clinical status and presenting complaint (i.e. whether the patient would likely to be admitted, if so under which specialty).

ED juniors will be assigned to different zones and they will take the responsibility of clerking the patient on a common proforma, which will be carried forward and not repeated, but reviewed by a specialty senior (ie, registrar). The specialty senior will provide direct supervision and a post-take consultant ward round will fulfil the training needs for the junior doctor in ED.

The number of zones will be dependent on the average take for each specialty and available juniors in ED. The ED juniors are expected to cross-cover depending on that day's situation.

ED seniors (middle grades and consultants) should look after the unstable and resus patients, whilst the rest of the ED juniors would be admitting/treating the patients under the direct supervision of

a specialty registrar or consultant.

The specialty team juniors will be working in ED and Medical Assessment Unit (MAU). They will review the patients following triage by ED, rather than waiting for the patients to be initially clerked by the ED doctor. They will also review patients admitted following GP referrals. This will result in more junior doctors available in ED by integrating the on-call teams.

Figure 1 is a simplified representation of our proposed model.

This model helps to address the following.

Staffing

ED juniors will be effectively part of the specialty team and vice versa, under direct supervision of specialty seniors direct, thereby reducing the pressure on the ED middle grades and consultants. ED seniors will concentrate on unwell patients and minors. Thus, this model benefits both teams in assessing patients in a timely manner and decision making.

As specialty teams will be working in ED and review patients immediately after triage, this effectively will compensate for the extra time taken by ED juniors to complete clerking of patient awaiting admission.

Duplication

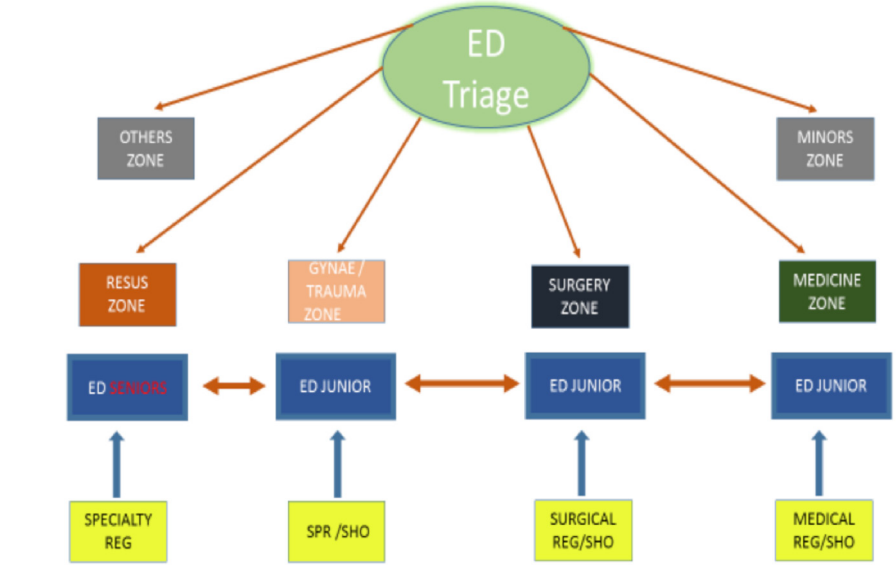
The ED juniors complete the clerking, which is carried forward by the specialty team, saving valuable time by avoiding duplication of work.

Specialist registrars will be able to supervise ED referrals and assess the GP referrals rather than clerking the patients. This minimises the delay in specialty review of ED referrals and also improves the safety for GP referral patients as they get reviewed immediately either by the specialty juniors or registrar on their arrival.

Training

ED juniors' training requirements will be fulfilled by consultant post take ward rounds/trauma meeting/ morning presentations etc, and they will have close supervision by the specialty registrars, increasing the educational value of these postings.

Figure 1 Simplified representation of proposed model



Solution 4: Board members should be elected

1. Members of boards should be elected every 3 years.
2. The electorate will be all staff employed by the hospital.
3. In addition, the local public at large will be represented by the elected council, which will elect an agreed number from within the elected council. Such individuals will also be subject to re-election every 3 years.
4. The chairman of each board will be elected by the elected members.
5. The chairman shall have direct access to the central NHS, to which it will also be answerable.
6. Candidates standing for election should not be representing any political party.
7. All candidates to be given equal exposure to the electorate.
8. Candidates wishing to stand for any of the executive posts shall declare the post for which they are seeking to be elected. Such candidates shall not be eligible to stand for any other post.
9. The chairman or a nominated non-executive member of the board shall be the nominated independent member to respond to concerns of staff or complaints. The existence and functions of such an individual should be widely advertised.
10. Candidates for election may be nominated by NHS organisations, NHS employees or members of the public.
11. This model should be adopted for other boards within the healthcare sector.

Benefits

1. This should encourage senior management to treat staff with respect, and ensure that staff are acknowledged for good work.
2. This should encourage transparent and open planning.
3. Management excesses should be curtailed.
4. Accountability should be ensured.
5. Changes in structure will be explained and justified.
6. Line managers will be obliged to act for the benefit of patients' care and concerns of staff rather than unquestioningly enact management decisions.
7. Fear and bullying should be reduced.
8. There will be more transparency in management appointments. Continued payment of a full salary when an individual reduces the agreed work sessions because of accepting a management role will require explanation.
9. Management will need to be seen to act on advice given by the different units within the hospital.
10. The appointment of management consultants will require justification.
11. There will be an independent responsible person to deal with staff concerns, including bullying.
12. Morale of staff should be improved. Staff will feel that they have a say and can contribute.
13. This will prompt non-executive members to be a lot more questioning than currently.
14. This will encourage management to seek innovative proposals and changes from staff.
15. Local wastage will be reduced.

Solution 5: Use understandable language

It is difficult for most people to appreciate how much the NHS costs; billions are unimaginable. The expectations of the public are increasing year by year, and yet increasingly the public fails to appreciate that there are limits, it fails to appreciate the vast sums of money that are wasted, and it fails to realise how much each one of us cost the NHS whenever we use its services.
The true cost of prescription drugs and the waste of time and money when people do not turn up for their appointments is also something the public do not generally appreciate.
The public are never given a clear description and explanation of the various changes made to the NHS; this results in increasing lack of interest.

Solution

1. The government should clearly state how the NHS budget is spent, how much money is devolved to each CCG and to hospitals, for social services and public health. There should be greater transparency about how money is spent locally. The words used should be concrete, short, and direct wherever possible.
2. Each time we use the services of the NHS we should be informed of the cost. Each prescription should have the actual cost to the NHS for the pills, the cost of consultations should be clearly stated, including the cost of operations and hospitals stays. The NHS collects a great deal of data; it should not be too difficult for the costs to be assessed. Once people begin to appreciate how much every item costs they will begin to question their behaviour and demands. We believe that most people are not callous and deliberately careless in the way the NHS is used and that people are capable of reacting appropriately to honest information.
3. This will undoubtedly reduce the number of wasted appointments.
4. The involvement of the public through participation in electing its local governing bodies and its ability to stand for election will prompt better dissemination of information and realistic expectations.
5. It is recognised that the NHS should change but the rationale of proposed changes must be clearly stated and not developed in secrecy.
6. The public at large will be involved following the establishment of electing boards.

Solution 6: Stop management consultancies

The NHS has many highly intelligent, thinking and innovative individuals across all sectors of the workforce. Should management wish to solve a problem, they should appoint a committee consisting of people from the hospital to find a solution rather than invite management consultants. Such a committee should be supported by managers who should not have any voting rights but may participate in discussions. The members of the committee should elect their own chairman. All necessary data required by the committee should be provided without delay. The committee should be given the right to co-opt additional advisers.
Should the subject under consideration involve other agencies, members from such agencies should be invited to join the committee but should not be given voting rights.
The committee should be given clear terms of reference, and the likely time scale for completion.
The formation and membership of such a committee should be public knowledge.
This process would save a considerable amount of money, and encourage more effective solutions suitable for the local environment and circumstance.

Solution 7: Miscellaneous

Merit award systems

1. Review merit award systems, particularly those at the local level. It is a common perception that hard working consultants are not rewarded. A requirement to show continued improvements in various domains is impossible for those clinicians who consistently devote their energies to the service of their patients. It also appears that rewards are given to those who undertake management roles and other paid appointments. Such people receive extra payments and therefore such roles should not be considered in the rewards. Individuals who indulge in creative writing are often rewarded because the system never checks the veracity of the contents in the application forms. The system should be made more transparent.
2. Consider similar award systems for other grades of staff.

Measure productivity of staff

1. Some Royal Colleges have guidelines for the number of activities of each clinician but no effort is made to measure this work.
2. The practice of recording productivity based on agreed guidelines should become normal practice.
3. Establishing this routine would lead to a more efficient service.

Matter for the Royal Colleges and Universities

1. Many within the service feel that there is loss of a holistic approach. It has also been suggested by many that district general hospitals are now far too specialised. Generalists are becoming extinct.
2. There is no longer a clear difference between general medicine and geriatrics. There is perhaps a case to appoint general physicians with an interest rather than consultants in geriatric medicine. Such consultants should be undertaking a greater community role than currently.

The Remorseless March of "You brought it on yourself"

Doctors are on the verge of collapse as a profession and the NHS is teetering on the edge too. And there are deepening shadows in health policy which hide an uglier truth: the ethics on which the NHS is founded and on which the profession relies are being corroded and corrupted for the sake of financial expediency and political gain.

The motive for this dark progression? The NHS as a whole has seen unprecedented cuts to its budget. Hidden as "efficiency savings", over £20bn of annual funding we should have had available to us has been stripped away. This is all in the name of austerity and, much like Naomi Klein wrote about, it is a "shock doctrine" of pushing through savage public sector cuts at times of a so-called "economic crisis".

General practice crisis

Every week we see GP surgeries closing due to lack of funding, the inability to recruit GPs and senior GPs just walking away due to the sheer pressure of the workload. Imagine that – GP surgeries closing down and patients left high and dry with no GP care. Other surgeries nearby get those thousands of patients forced onto their list by NHS England exacerbating the problem further. All this is making many GPs unwell and some are suffering serious mental illness due to the pressures involved. Many GP surgeries are now short of 2-3 GPs as the workload increases.

Doctors are now working in unsafe environments with no time to think or spend the time they need with patients. This is the same for hospital colleagues.

Medical colleagues cannot use the "it all seemed better in my early days" argument, as the NHS is now so short of staff and funding along with the demand for care being so high that it just isn't possible to make comparisons. The sheer complexity and co-morbidities GPs deal with in an 8 minute consultation is mind boggling. Many patients have 6-8 complex diagnoses and are taking over 20 different medications.

General practice funding has fallen from around 12% of the whole NHS budget down to around 7% now – imagine such cuts and the impact it has on day-to-day care. All the time demand has soared and we have to deal with a government hell bent on pushing through "7 day working" when we can't even provide a safe 5 day service.

The corruption of ethics

In the midst of all this, a parallel and disturbing trend reflected in recent changes to CCG rules governing criteria for some elective surgery shows a deepening crisis in ethics.

Vale of York CCG was the first to bring in a rule change whereby if someone's BMI exceeded 30 they would be excluded from a range of elective surgery because they were obese [1]. Since then, several others have followed suit [2]. If you need a knee or hip replacement in those areas – no matter how much pain you are in – if your BMI is above that value, the CCG has made it plain it is not going to fund that procedure.

Doctors have to weigh up conflicting risks against benefits all the time. Quintessentially, that is the hallmark of medical ethics. "First, do no harm" – but will this procedure which has risks probably yield far more benefits? "Do good" – but will the prescription I am giving encourage multiply resistant strains of bacteria to emerge over time, even though the patient would have recovered over a longer time without the drug? It is the reality of medicine.

But this trend is different. It is taking a risk factor – in this case obesity – and turning it to a fixed, immutable point on a tick-list. No clinical judgement required or even allowed, thank you.

Making ethical judgements in medicine has to consider likely outcomes. This means having the ability to weigh up all the values and principles of a problem, then consider the consequences before arriving at a judgment. That does not mean any two ethical judgments over a subject will be the same. But it does mean that the decision has been arrived at using sound ethical principles, to the best of someone's ability. Part of being a professional lies in making judgments in this way. That is removed, in one stroke, by these governing guidelines.

Some might classify the likely outcome of the CCGs' ruling as a form of cruel and unusual punishment. If you need this operation, if a clinician looking at you would still have opted to go ahead after weighing up all the risks (notably your weight), because they believed you would probably still benefit despite them, the funding body says no. Why? Because you are too fat, Mrs Jones. Sorry. There you lie. In your pain. Pay out of your pocket or pay with your suffering.

Are CCGs composed of cruel, heartless people? No. But look at *their* governing principles. Rationing funds to yield the greatest benefit to the greatest numbers. And it's getting worse, as this government flatly refuses to heed warning from all quarters that the NHS has no more "efficiency savings" (ie, cuts) to be made. So a CCG's governing principles have to be applied even more urgently. How do they save that much money? Arbitrary rulings which take existing clinical risks and make them a fixed classification of eligibility are more appealing. In the hope, no doubt, that they can always raise "clinical risk factor" as a defence.

Ethically, this is groundless. By not allowing any leeway, the basis on which ethically defensible decisions can be weighed up is removed. It's at best a non-ethical decision. But with consequences for the suffering and well-being of many real people.

This is wrong in two main ways.

First, it is inherently unfair. Removing the chance for someone to have their suffering eased on grounds which have no clinical justification, but are driven solely by costs, when someone else in the same area in the same amount of pain can still be classified as "acceptable", is iniquitous, arbitrary, and unfair.

Second, it is corrupting. It has taken an ethical principle used by doctors - the calculating of surgical risk exacerbated by obesity - as part of reaching a clinical judgment which weighs up several conflicting risks and benefits. So someone that obese might have been declined surgery, all things taken into account. And has made it an absolute ruling. Against which no clinician should appeal. That's it. Despite the fact that in many cases the doctor would say not operating is on balance unethical. It has corrupted a sound ethical principles and made it a fixed, market-defined rule. Because the driver is money, to the exclusion of other concerns.

This is what Michael Sandel refers to in *What Money Can't Buy* [3], when he describes the intrusion of market "norms" into non-market areas – like healthcare. The inevitable result is unfairness and corruption. Yet this government not only favours this destructive intrusion, it clearly intends to encourage it as it wreaks further havoc with our NHS. Refusing hip and knee operations are going to be the thin end of a very large and bloody wedge. Unless it is stopped.

Blame the victim

As professionals, doctors should not ignore the wider narrative either. Rulings like this add to the growing narratives which support the view of an "undeserving sick". A recent poll by the BBC [4] showed an uncomfortably close division between those who favoured "charging for diseases and illnesses caused by their lifestyle" and those who did not. In the forties percentage wise, both ways. The don't chargers had it, but not by very much.

This is disturbing in three ways.

First, the very notion of charging for some forms of treatment was until recently not regarded as something "normal" to talk about, outside the right-wing think-tanks who have been espousing it for decades. Yet now it's regarded as mainstream debate. Which is exactly what those seeking to replace the NHS with a system that charges directly want. By "normalising" the debate, it becomes so much easier to persuade the public that this is the "right" thing to do. The emphasis is not on the parlous state of NHS finances as caused systematically by government policy, which would be fair enough. It is about the "need" to charge "to make ends meet". Add to that the number of stories about how "inefficient" the NHS is, and it's easy to see where the desired direction of opinion is. This is consent that is being manufactured to end the NHS.

Second, the view that people should pay for some types of illness or injury out of their own pocket is again both unfair and corrupting. Unfair because most people are already paying for the NHS in their taxes. Why should they then have to pay twice? That feels like a fine – a punishment. For some assumed "bad" behaviour. Are they to be given a fair hearing, then? No.

Third, it's the reference to "lifestyle choice" that is the sinister trend. People are being condemned as "unhealthy" because of deliberate choices they have made. Despite the fact that in the reality many of these people find themselves in, the choices are actually perfectly rational – a reflection of disempowerment and lack of opportunity, not irresponsibility. Yet they are condemned out of hand: "lazy", "feckless", "'fat", "a drain on the public purse". So, the leap in thinking goes, they should not benefit from "free" NHS treatment.

That is corrupting: it corrupts the founding principle of treatment for all free at the point of delivery to one based on merit, gauged by arbitrary social standards. And punishment, triggered by in effect withholding treatment. A currency of blame and pain, against which the Royal College of Surgeons has spoken out strongly [5].

Take action

No civilized society should have anything to do with this growing shadow. Medicine as it should be practised, quite simply, cannot abide it. Yet on it goes. Corrupting and corroding the NHS, making unfairness and inequality manifest.

We should direct our anger and frustration towards those who have brought this about – the politicians – and be sympathetic and understanding of medical colleagues, many of whom are at the end of their tether and hate going to work each day.

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"Efficiency savings": A PR double whammy

As a clinician in the NHS I always found the concept of efficiency savings a demoralising one.

The clear message seemed to be that we were a group of possibly well-intentioned but inefficient bumblers, who could readily make ourselves more efficient and save money for patient care if we put our mind to it.

Every now and then someone would discover a way of saving money that worked, but this seemed to be offset by attempts at cost saving by buying alternative cheaper equipment that didn't do the job properly, or just delaying replacement appointments for as long as possible. As the years went on it became increasingly hard to imagine that any quick wins in the efficiency arena had not already been discovered.

When I served on the Trust Board I was confused and irritated by the term "efficiencies" being used as a shorthand. When I queried it, I was told that it meant that the Trust had to make savings of a certain percentage of the annual budget every year.

"Oh, you mean cuts'" I said ingenuously. There was sharp intake of breath.

"We don't use the 'C' word here" was the Chair's reply.

Of course, all extra funding spent on the NHS includes this money ripped back from trusts making their "efficiency" savings – the DoH reduces the budget to take account of these 'savings' and then gives the trust an "uplift" in funding. It's like robbing Peter to pay Peter.

But why are they called "efficiency savings"? In economic terms it makes a sort of sense. Efficiency is the ratio of output to input. The output of a hospital is the number of patients seen and treated, while the input is the money spent. So long as the hospital keeps treating the same number of patients, and the budget is reduced it has become more efficient. The fact that trolley waits get longer and quality of care goes down because of staff shortages doesn't affect the economic measure.

> "That's the standard technique of privatization: defund, make sure things don't work, people get angry, you hand it over to private capital."
>
> *– Noam Chomsky*

And it's a win-win for the politicians. Not only do they have imaginary extra money that they can announce as new NHS investment, but they are also giving an impression of a persistently inefficient service that can make savings every year just by getting its act together.

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