

Is it Safe?

The parlous state of NHS dentistry

– Page 7



NHS

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Catching the Tide

'There is a tide in the affairs of men, Which taken at the flood, leads on to fortune. Omitted, all the voyage of their life is bound in shallows and in miseries. On such a full sea are we now afloat. And we must take the current when it serves, or lose our ventures.'

— *Brutus, in Julius Caesar, Act 4 Scene 3*

The tide has been going out for public services for many years. Politicians such as Oliver Letwin have dreamt of 'privatising the world' in the 1980s and this has continued relentlessly ever since.

British Gas was one of the earlier sales under Mrs Thatcher; soon to be followed by British Steel, BP, water, electricity and others, including British Rail. In the NHS, outsourcing of cleaning and catering started in the Thatcher era, together with the purchaser-provider split, general management and the concept of Trust hospitals as businesses, while long-term in-patient care was considered as 'social care' and was no longer provided. New Labour provided a very welcome and necessary increase in funding, but their 1997 manifesto promise 'to restore the NHS as a public service, working co-operatively for patients, not a commercial business driven by competition' did not outlast Blair's election. PFI contracts, private provision of clinical care and wasteful marketisation have unfortunately developed exactly as predicted by Allyson Pollock 12 years ago in *NHS plc* [1].

Since the financial crisis, austerity and Lansley's Health and Social Care Act 2012 ('no top down re-organisation', indeed!) we have been all too aware of the 'efficiency savings', 'cost improvement targets', pay freezes and staffing cuts. 20% of hospital beds have been lost in the last 10 years, 9746 since 2010, leaving us with fewer beds, doctors and nurses per head than almost any European country. In the first week of January this year, bed occupancy was 95% nationally and 40% of hospitals declared

an alert because of bed shortages. Under the Sustainability and Transformation Plans (STPs), all designed to save money, further bed cuts are planned to achieve £22 billion of savings across the service although everyone knows this cannot be done safely. Staffing is at crisis point, worsened by cuts to nursing bursaries and by Brexit, and by loss of young doctors who are moving abroad or leaving medicine altogether. One in ten junior medical posts is unfilled, with a shortage of at least 6000 doctors, and the RCN estimates that 40,000 nursing posts are unfilled. Accountable care organisations (ACOs), with capitated and doubtless inadequate funding, are planned.

Away from the NHS, all remaining public assets and services seem to be for sale or are already in private hands and are suffering damaging funding cuts, from schools, probation and prisons to air-sea rescue and air traffic control. Huge cuts in council revenues are having a devastating effects on services, and even more cuts are planned in future. The quality and availability of personal care has plummeted, delaying hospital discharges. We have all seen closures of children's centres and libraries, unfilled potholes on local roads and threats to sell off or privatise parks.

Is this really what people want? It would seem not. The website 'We own it' [2] shows that voters, even most Conservatives, feel that major services like the NHS, schools, Royal Mail, railways and water should be publicly provided. They are no longer happy with 'whatever works'. A social attitude survey in late June showed too that most people are sick of austerity and would be prepared to pay more in tax to fund services. In a Mori poll in May 2017 the NHS, rather than immigration or Brexit, was cited by 60% as one of the most important issues for Britain, the highest level in the last 15 years; and three-quarters were concerned that it was underfunded.

But has there been a change of mood? Labour's manifesto and Jeremy Corbyn's election campaign seem to have both tapped into this and encouraged it, with a huge surge of support.

The Grenfell Tower tragedy has also had an impact and has rightly focused attention on the public sphere. We expect avoidable harm to be prevented by laws and regulations, by building codes, food safety inspections, fire safety policies and many other issues which affect us all. The folly of Cameron's 'bonfire of red tape', calling for (among other things) laxer building regulations, is plain for all to see.

We may not often think about the consequences of cuts to our Council's emergency planning teams, numbers of fire safety inspectors and public health services, but the Grenfell tragedy and the council's lamentable response has shown what can and eventually will happen.

Are we, as Rachel Clarke asks [3], facing a Grenfell-style disaster in the NHS, with widespread failures of care, or will sense at last prevail as the public belatedly realises the risks of the current plans?

For public services the tide has been ebbing for years but things may be starting to change. Could this be the moment of opportunity, if not yet a full sea, at least a current serving us which we must take? Campaigning has never been more important.

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No Swift Answer

The ethical aspects of Charlie Gard's t

No publication is complete at the moment without an article about the unfortunate Charlie Gard, and he must be a lesson to us all.

The ethics have been debated and the human elements discussed but missing in all this is: why are we here and how could we avoid being here again?

Charlie Gard had a condition for which no one was to blame. It results in a gradual deterioration of muscle function accompanying progressive atrophy of the brain. This latter has unfortunately been labelled 'brain damage', which it is, but damage has somewhat emotive overtones. There is no treatment but various remedies have been postulated which may or may not have an effect on the rate of deterioration, thus raising the hopes and expectations particularly of the patient's unfortunate parents. No remedy causes recovery and return to a 'normal little boy'.

All ethics committees will be familiar with the discussion. Clinicians feel that treatment other than supportive is futile: parents and their supporters want to clutch at anything which sounds hopeful, usually without evidence, let alone feasibility.

Take a step back a year or so. Where would treatment of, for instance, congenital heart disease be if the prevailing view of the day had not been challenged? In 1936 the possibility of a surgical approach to the persistent arterial duct (PDA) was dismissed by the leading lights of the day as preposterous: death will result, endocarditis will ensue. With (at that time) no new treatments committees or ethics groups to contend with, it quickly became a straightforward operation and later an endoscopic procedure.

I remember as a registrar the early days of coronary artery stenting when eminent surgeons were asking not 'when' should this

rs or Easy Hope

treatment – by medicine and the media

procedure be done but 'if' it should be done at all because they had had to deal with some of the complications inevitable in the early experience. That their own early experiences were dealt with by only the coroner and the undertaker was by then long forgotten. None of them would now demand surgery where stenting is the management indicated. Left to them there would not be any stenting.

There are other congenital heart disease examples of opposition to experimental or non-evidential treatment, defying the view of the day, which through persistence are now routine. Should ethics committees say 'give it a go', supporting the family's wishes, if there is an experimental treatment? There is precious little to be lost providing no harm comes; or should they talk about compassion, futility, the best interests of the child, quality of life and such? Sir Robert Hutchinson (he of Clinical Methods) cautioned against "zeal for the new and contempt for the old" but a different adage of 200 years earlier suggests "be not the first by whom the new [is] tried nor yet the last to lay the old aside" (Alexander Pope, 1711). The balance will always be difficult to achieve.

There are a number of really vexed questions which must be debated every time. What is meant by best interest, in Prof Margot Brazier's words "a phrase easy to utter and difficult to interpret"? Who knows what is quality of life for a child who has no experience of life other than in a hospital cot attached to an array of equipment? These are often overlaid by over-interpretation of the level of awareness and appreciation of its surroundings by the unfortunate infant, by parents and grandparents.

More important, who can decide what quality of life is going to be, with or without treatment of uncertain outcome as time goes by? Should



quantity of life prevail over quality? How are the child's interests to be represented? That must certainly be independent of parents and of the treating clinicians. This representation should be possible at an early stage and ethics committees will always try to consider it but getting across to parents the need for it to be independent of themselves can be difficult and ethics groups, however hard they try not to be, unfortunately look like a manifestation of 'the hospital' and its staff.

One of the things which certainly did not prove helpful in the discussions over poor Charlie's management was the emergence of a seemingly self-appointed public relations team, that PR undertaking also to provide a journalism role. This must have been particularly confusing for Charlie's parents who were also obviously receiving formal legal advice, the greater volume of material coming from the PR system. Latterly the PR system appeared to be somewhat out of control and pursuing its own agenda. From this came also the intrusion of uninformed advice from several eminent sources as well as "Charlie's Army", and direct attacks on Great Ormond Street Hospital as well as the court.

A curious intervention coming from the PR-journalism system was the remark that "this is the kind of thing that can happen when the State gets involved". Exactly which element of the state was envisaged and which element in the dispute or the parties involved represented the state is difficult to imagine.

Of interest also is the anti-Obamacare lobby in America using it as an example of

what happens when there is state-provided healthcare. Presumably, if you are paying, you can have whatever you want regardless of indication or need.

What is certain is that to generate an enormous PR-journalism machine does little to help come calmly to an equitable solution. Connie Yates (Charlie's mother) remarked, very understandably, that all she wanted was some tranquillity as the saga drew to its sad conclusion. To some extent this will always be forfeited once the event leaves the confines and quiet of the interview room adjacent to the ICU. Advice from those others with experience in treating the condition is clearly important but where that advice is given without knowledge of the specific clinical features and with a commercial interest, it can only be viewed with suspicion.

The origins of any such dispute are differences of opinion based on differing levels, realistic or unrealistic, of understanding coming from interpretations of clinical signs or reports of experimental work emerging from, often single issue, web-sites, but it is not unreasonable to clutch at such straws. More unhelpful is cross-fertilisation of ideas from other families, usually with dissimilar conditions, as well as different views within the family involved.

I suspect that on many occasions reason prevails through some good explanations and helpful local mediation, and the sad event draws to a conclusion never to emerge into the public arena.

One of the more salutary, and often very moving, lessons we have seen, bravely committed to print in the last few weeks, is of the agonising decisions required of parents, and this has not come from a journalist's interpretations but from parents themselves. We have seen narratives of what can happen when a severely

compromised life, if life it can be called, is allowed to continue and its effect on the family as well as the continuing feelings of guilt when a different decision has been reached. Both have re-agonised over whether their decision was correct at the time. Each is individual as is the decision each time it becomes public. Many will remember Charlotte, the Southampton patient, whose life, again if life it can be considered, continues, whose parents have since gone

their separate ways as the result of caring for her; and now the burden of whose care is in the hands of very dedicated foster carers.

Can these disputes be prevented? It is probable that many are and we never know about it, but they take a lot of undoing once the sides become

entrenched and from some experience of this, that can happen behind closed doors, without the other realising. Some will inevitably continue and inevitably become public.

The Pandora's box once opened releases all manner of unforeseen consequences as we have seen, and Connie and Chris now realise; but as of old, hope remains. A sad beginning with an even sadder end. We can only hope it does not serve to release a further cascade.

Many lessons to be learned and some, hopefully, learned.

“... to generate
an enormous PR-
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calmly to an equitable
solution.”

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Pulling Teeth

NHS dentistry continues to fare badly through deliberate political choice

As a dentist, I'm highly committed to the NHS. I'm also proud of the strong commitment to the NHS shown by fellow dentists (trainees in oral surgery) during the recent industrial action by junior doctors over concerns about staffing levels and patient care.

It would be nice to believe that the government felt the same commitment. After all, they frequently say that they do. But since we all have a background in science, why don't we follow the appropriate methodology, and look at the – often depressing – evidence? The English system, in particular, does not come out of this very well.

We hear much about the importance of integrated care in the NHS, yet politicians seem to have deliberately designated dentistry as the poor relation in the NHS family. A Cinderella service, if you will. This might seem unfair, labelling medicine as an ugly stepsister – but at least medics get to go to the ball.

For starters, the NHS has a concept of being free at the point of delivery. This just isn't true with dentistry for most adults. NHS charges, in England especially, have ceased to be a mere 'contribution' towards the cost of NHS dentistry – in the past 2 years dental charges have increased by an inflation-busting 10%. They are quite simply a tax on health. Charges came about in the 1950s because of the exceptional demand for dentistry and the recognition that there was a limited number of dentists – a contribution towards treatment would lower demand – but in the 2010s they have become a substitute for adequate government investment [1]. Oh, and there are still a limited number of dentists.

It's not simply that our patients are having to put in more. It's that government has settled on a way of ensuring it has to pay in less. We

are heading to a point where charge revenue ends up exceeding direct investment from government within a generation.

The decennial Adult Dental Health Survey [2] showed that over a quarter of adults say that the type of dental treatment they opted for has been affected by the cost of treatment – and almost one-fifth say that they had delayed dental treatment for the same reason. Dentists are already the subject of sufficient phobia: adding the fear of how much treatment will cost is of no benefit in ensuring that patients receive necessary treatment in a timely manner.

Does it have to be this way? No. Only in England are charges surging. Wales has frozen fees, and the proportion of budgets drawn from charges has fallen across the board over the last decade.

But the patients who avoid visiting their dentist with conditions like toothache or abscesses aren't simply grinning and bearing it. Studies have estimated over 600,000 try to get help from their (already overstretched) GPs. This is madness. These visits come with a £26 million price tag, and usually end with a referral back to an NHS dentist.

Speaking of referring back, perhaps a little history is in order. This is not an austerity issue: chronic underfunding of NHS dentistry prevailed even in relatively flush times. Back in 2006, the government imposed a controversial contract based solely on the number of units of dental activity (UDAs) achieved by dentists. The new target-driven contract has had a corrosive impact on the way dentistry is delivered to patients, and on how dentists feel about providing services for the NHS.

It brought in a fixed budget for NHS dentistry because dental practices were limited in the amount of NHS care they could provide patients, depending on how many UDAs they

were commissioned to deliver in their contract.

If a dental practice were contracted to say deliver 1200 UDAs over the year, the expectation would be that these will be spread out evenly over the year. If the practice reaches its quota – and spikes do happen! – sometimes dentists are forced to turn away patients, regardless of need, for fear of breaching their contract. Senseless targets without any regard to patients' needs.

Dentists receive financial penalties when they don't hit targets, receive no compensation when they exceed them, and have no scope to take on new NHS patients, even when they have spare capacity. This has led to a conveyor-belt model of provision. NHS dentists are forced to chase targets for curative treatment, rather than provide vital preventive care. This topsy-turvy system means dentists are paid the same for doing one filling or 14, and are routinely subsidising care for high-needs patients out of their own pockets.

NHS England has an unhelpful "one-size-fits-all" model of commissioning. A practice located in a big city, with a large fluid population, might treat many more emergencies than its rural counterpart but some commissioners refuse to take this into account. The irony is that you can have patients in need and dentists in the same area who could provide more NHS care if only they were commissioned to do more.

In fact, the government only commissions dentistry for 56% of the population: even with private dentistry providing a service, there are far too many people without access to an NHS dentist. Less and less money is spent on dentistry nationally, which obviously means that fewer and fewer people will have access to an NHS dentist.

The notion of people not being able to find help when they are in pain is unimaginable in any other NHS sector. Imagine the outcry if somebody broke a leg and was told that unfortunately the NHS has only commissioned doctors to treat 56% of the broken bones nationally. I do hope Jeremy Hunt doesn't read

this and take that as a suggestion. [*Be careful what you wish for... Ed.*]

BDA surveys show that the impact of this crude-target driven contract has not only demoralised the profession but has also driven many dentists out of the NHS altogether. The shambolic introduction of the 2006 contract – some dentists only received the lengthy complex contracts on the same day they were expected to sign them – resulted in one in 10 dentists walking away from the NHS.

Money matters to dentists because every penny comes from our own pockets. Unlike our medical colleagues, general dental practitioners (GDPs) don't receive any capital investment from central government – our taxable income is the only pot of money going when it comes to investment, whether it is to pay staff, invest in premises, equipment, materials and laboratory costs. And when we're squeezed, so is the service that we deliver.

The refusal to lift the public sector pay cap [3] is hitting NHS professionals hard across the board, but for dentists it can make the difference between balancing the books or going bust. Associates and practice owners in England and Wales have seen taxable income fall by 35% in real terms [4] over the last decade. This unprecedented collapse has a real impact on our ability to deliver the improvements in facilities, equipment and training that our patients deserve.

It's a story that's replicated in Scotland and Northern Ireland with fall in real-terms income of over a quarter since 2009, among both associates and practice owners. And it really shouldn't surprise anyone that NHS practices in Wales and in isolated locations such as Cornwall are reporting that it's increasingly harder to recruit associates.

For dentists, there is a crisis of confidence in the NHS. Heavy workloads, excessive administration, unreasonable targets, and concerns about litigation and patient complaints are all taking their toll.

I fear we may also be seeing the demise of

the family dental practices as the ability of large dental corporations to use economies of scale (eg when bidding for NHS contracts) is pricing the smaller practices out of the NHS. Big isn't always beautiful as GPs and GDPs know to their cost when the NHS hived off its back office function to Capita for a reported £8 billion contract – a role that became possible after the government brought in the much criticised 2012 Health and Social Care Act. Dentists who were keen to provide NHS care were forced to remain idle [5] – some for up to a year – as the company floundered to provide the necessary credentials for dentists to do this work.

So, surely, the government would like to help out, given its frequent fulsome affirmations about the value of the NHS? Well, not so much. The dental contract has been deemed unfit for purpose not only by dentists, but also by patient groups, both main political parties, the Health Select Committee and the chief dental officers for England and Wales alike – because it wrongly focuses on meeting activity targets, rather than on patient-focused preventive care. However, progress towards a reformed contract has been slow – a new clinical pathway towards prevention was pilot tested from 2011 onwards and worked for dental professionals and patients alike – but the government refuses to invest in prevention, despite the long-term benefits.

It's time for a responsible approach to funding. One that doesn't hinge on our patients putting in more through charges, just so ministers can pay less – and be seen to be doing so.

The profession has argued that dentistry in England should be based on a 100% capitation model. The government will not be persuaded on this, clinging on to the 'benefits' of the UDA system. The BDA believes that we urgently need a new contract which is patient-focused and preventive. More than £20 billion has been spent over the course of the last decade through the current flawed arrangement. With more involvement from the profession, the same amount of money might have been spent

– but it would have been spent better, with further-reaching outcomes and a proximity to universal provision which underlies the values of the NHS.

The government must recognise the heavy demands placed upon GDPs and start addressing the causes of poor morale. If it fails to do so, it won't just be dentists' morale that is suffering.

Patients who rely on NHS care will lose out if we see a repeat of the pattern we saw in 2006, with more dentists moving into private care where dentists' satisfaction seems to be higher. I began by asking whether the government is truly committed to the NHS. If it is, then now would be a very good time to prove it.

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Can We Afford to Close Any More A&Es?

Evidence from North-West London

Gurjinder Sandhu presented these findings to the AGM of Keep Our NHS Public in June. They are compelling. So much so that he was invited to speak at our AGM in York in October (see page 32). This is a short summary of what he has to say.

Gurjinder starts by outlining the strategic planning that is behind the series of closures and downgrades of A&E departments in North-West London, where he works as a consultant in acute medicine: the *NHS Five Year Forward View* and the STPs it fostered. STPs call for the downgrading or closure of up to 24 emergency departments in England, under the wholly untested assertion that large numbers of seriously ill people can be kept out of hospital and cared for in the community.

For North West London, this has meant that a programme of A&E closures is already underway: two Type 1 A&E units (those treating the most seriously injured, and possessing the most advanced and comprehensive facilities) were closed in 2014 and the local STP envisages a further two closures in the area. This would be alarming enough were it not for the fact that this is far from atypical across England.

Analysing the performance of the affected units by 4-hour target is illuminating (Figure 1). Gurjinder demonstrates a clear 'knock-on' effect of a nearby unit closure on those around it. This effect cannot be ascribed to increasing overall attendance.

The damage does not of course stop there. Delayed transfers of care (DToC; the unkindly named 'bed blocking' in the lay press) have a remorseless and undeniable effect on hospitals, and their A&Es (Figure 2).

Add to that the predicted increase in elderly population for these areas, and it is all too easy to see where this leads in human terms. Gurjinder gave a heart-rending description of the patient he called 'the hypothermic Granny':

elderly and hypothermic, afraid and frail, who is admitted to A&E suffering from the sustained effects of cold, poverty and isolation, but who nearly always rallies remarkably when warm and given the care they need. 'Am I going to send her back to her cold home, knowing full well there is no social care for her?', he asked. There, in that simple medical ethical question, we see the folly and horror of this government's callous indifference to what their treatment of the NHS is doing to people who simply cannot fight back.

Anyone who works in A&E has plenty of anecdotes about the human condition, of course, but relaying these to the statistics so well lends an added strength to the argument which, in the end, is about political choices and their consequences for real people.

Gurjinder concludes by pointing out that:

- A&E closures in North West London aggravate already existing health inequalities.
- A&E closures have a negative impact on neighbouring A&E performance.
- Worsening performance is not accounted for by increased overall attendance.
- Social care cuts and DToC impact on patient flow, hospital capacity and A&E performance.
- 'Time is tissue' – delays in getting treatment might well seem 'cost effective' in a plan, but the real cost will be measured in worsening outcomes and lives lost.

A convincing and robustly presented case which gives the lie to the 'patient choice' myth.

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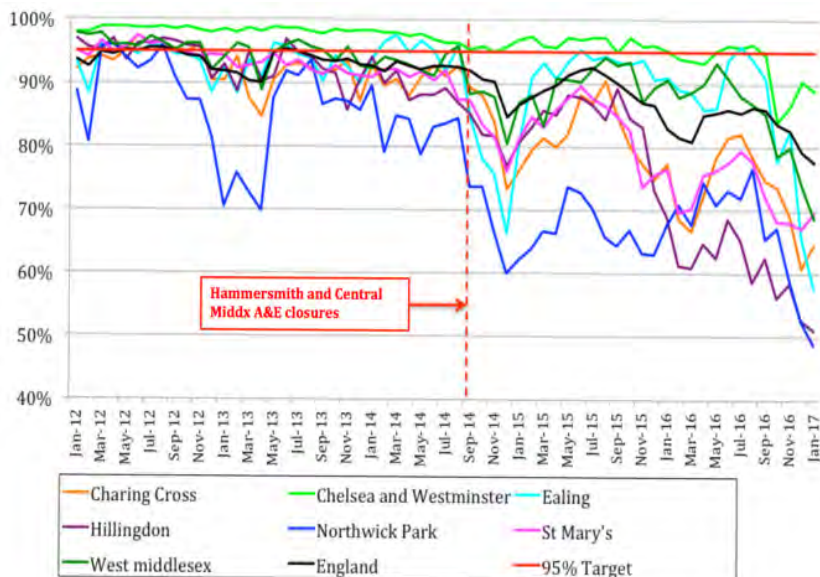


Figure 1 Type 1 A&E performance by 4 hour target

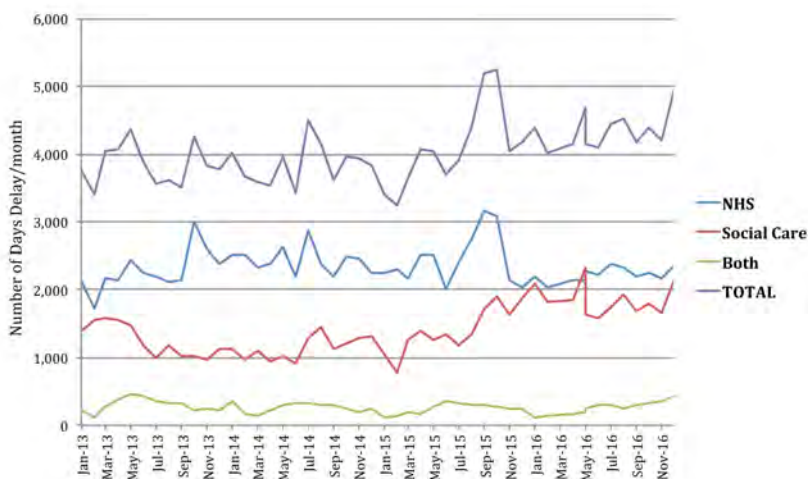


Figure 2 Delayed transfer of care (DToC) in North West London local authorities by attributable organisation

Winter is Coming ... All Year Round

'Winter pressures' are becoming an all-season risk

One sign of NHS crisis is the frequency with which hospital trusts declare that they cannot cope with demand. We may expect around 2000 such incidents in England this winter, if last year is a guide.

Many relevant indicators are growing annually, pointing to a worsening crisis which is not confined to winter. There is also striking variation, with some Trusts declaring no alerts whilst others are on almost permanent alert, particularly in areas of southern England.

The Nuffield Trust have written on the problem [1], and NHS England published data last winter which is summarised in a Parliamentary Report [2]. I mention some of their key points, report some feedback, suggest how the data can be modelled and ask questions, hoping for a discussion!

What used to be called "black alert" and "major incident" are now rebranded as Operational Pressure Escalation (OPEL) Level 3 and 4. Formally, these two OPEL levels mean:

- OPEL 3: The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are required across the system by all A&E Delivery Board partners, and increased external support may be required.
- OPEL 4: Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions

taken, external extensive support and intervention required.

A Nuffield Trust blog last winter included animated maps showing where the Level 3 and 4 alerts occurred each week [1]. A map of the total Level 3 or 4 occurrences Dec 2016 – March 2017 (Figure 1) is shown in the Parliamentary Report [2, p.4]

Because the OPEL definitions are new, and the previous terms ("black alert" etc) had no standardised meaning, there is no easy way to compare this situation with previous years. However, a separate Nuffield Trust report [3] analysed data stretching over 2010-15, pooled across England, for 15 indicators that contribute to winter pressures, whether or not they cause OPEL alerts.

For example, during 2010-15 attendance at Type 1 A&E units (Consultant led 24 hour service with full resuscitation facilities and designated accommodation) rose by 7%, as did emergency admissions. Attendance by elderly patients peaked in winter; unlike attendance by other age groups. The number of overnight general and acute beds decreased by 7.5%, a loss of 8,000 beds over the period. The average daily percentage of acute and general beds occupied was around 94-95%. Delayed transfers of care (DTC – patients unable to leave hospital due to lack of other NHS provision and/or social care) rose, particularly since 2013, with lack of social care increasingly responsible.

NHS England has published data from daily "Sitreps" [4]. For each Trust on each weekday from 1 Dec 2016 to 10 Mar 2017 (weekend data is amalgamated), the data includes OPEL Level 3 and Level 4 alerts, A&E divers, A&E attendance, Emergency Admissions, Bed capacity and occupancy, Beds closed due to Norovirus / D&V, and Critical Care bed capacity

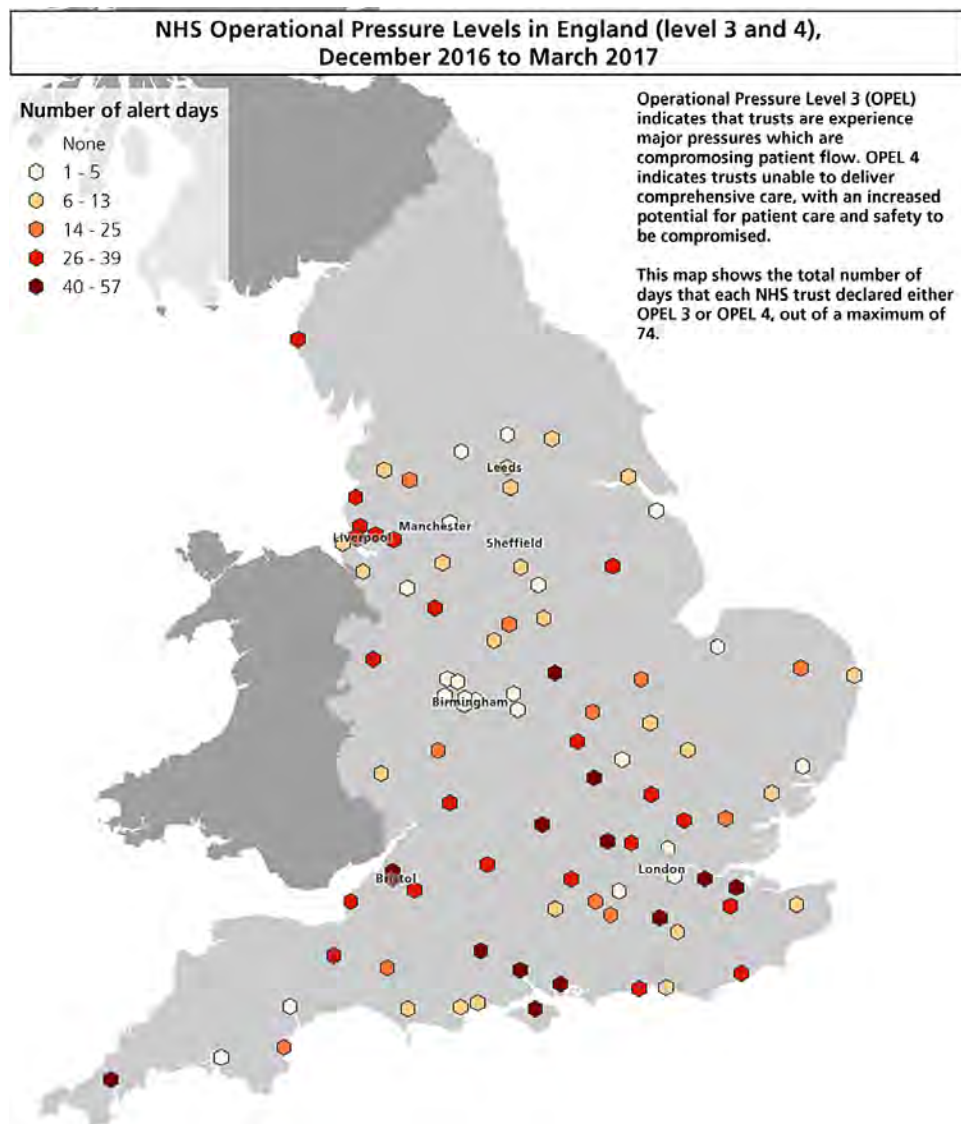


Figure 1 Reproduced from [2]. Contains Parliamentary information licensed under the Open Parliament Licence v3.0

and occupancy.

The Parliamentary Report [2] gives a good summary, without trying to identify which factors actually cause the alerts. For example, bed

occupancy is a likely culprit. But bed occupancy rates are very high in London, where almost no alerts were declared. The report lists the Trusts with the highest number of alerts, many

of which are in southern England. But is this due to high bed occupancy, emergency admissions, norovirus, demography, or something else?

An activist in Leicester (where the University Hospital had 29 OPEL 4 and 20 OPEL 3 alerts last winter) commented that the city population has very poor health and this very large A&E is permanently under pressure. Bottlenecks include insufficient bed capacity, insufficient staffing capacity and insufficient physical space in A&E, which had capacity for about 120,000 while dealing with over 200,000 attendances annually with both attendances and admissions going up yearly. There have also been DTOC problems, partly internal, partly external. Most problems persist but a new A&E opened in April. It does not run entirely smoothly but has more space than virtually any other A&E in Europe. The Trust is being allowed to keep its beds and even expand them (reversing this element of the STP). A system introduced about 6 months ago to speed up 'through-put' has had some results.

Clinicians in Chester (11 OPEL 3) were convinced that their problem is bed availability, rather than A&E delays, lack of space in A&E, or staff shortages. There has simply been nowhere to put the patients.

Senior community nurses in Merseyside (4 hospitals, total of 109 OPEL 3 and 2 OPEL 4) said that alerts are not caused by norovirus, or problems with critical care beds which are almost always full. They thought that high bed occupancy combined with high attendance at A&E is the problem, rather than bed occupancy per se, and that high attendance at A&E is caused by lack of convenient alternatives, and by ambulances just taking patients to A&E rather than to those alternatives which do exist. In some rural areas, transport problems will force people to attend A&E and there may be no alternatives. They were impressed by the coordination of acute and community services at Guys and St Thomas', and thought this may be why London has few alerts despite high bed occupancy. In Manchester, a walk-in centre

adjacent to the hospital relieves pressure. In their experience, when the hospital declares an alert, GPs and community staff are told to avoid A&E, but "we're already doing this anyway". However, they also had negative experiences of community staff being forced to take on patients who were not suitable for intermediate care, or whose home circumstances had not been investigated before discharge. In their view, neither the hospital nor anyone else was analysing the overall problem.

The winter pressures data does not cover all of these issues. It may not be completely accurate, as NHS England acknowledge. Aside from that, do different managers interpret the definitions consistently? Are there other motives for declaring OPEL alerts? In any case, alerts are not the only issue. Better community provision may reduce strain on hospitals, but if patients are inappropriately discharged or diverted from hospital to other facilities, only to return later with an illness which could have been treated earlier, alerts may be avoided but the outcome, and the strain on other services, is worse.

However, I've been looking at the data, using models in which variables like bed occupancy rate, emergency admission rate etc. are supplemented by unknown random effects for each region, STP, and NHS Trust. The variables can also be averaged over the STP to which the Trust belongs. With that approach, the key components associated with alerts are bed occupancy, average bed occupancy over the STP, average attendance at Type 1 A&E over the STP, and the interaction of these two averages.

There are other strong predictive factors for an alert on a particular day: whether the Trust was on alert yesterday, the proportion of Trusts within the STP which were on alert yesterday, and whether it is Mon/Tue or later in the week (I'm excluding weekends, specialist and children's hospitals, and focusing on hospitals with Type 1 A&E). If these three additional factors are included, the other key variable is average bed occupancy across the STP, and to

a lesser extent bed occupancy in the Trust itself.

The random effects represent all the rest of the unexplained variation. They show large, significant differences between regions, STPs and individual Trusts. Hospitals in London are much less likely to declare alerts, while those in southern England are much more likely. The Royal Cornwall Hospital has the highest combined effect of region, STP, and Trust, although lower bed occupancy reduces the actual number of alerts it declared. The rest of the top ten (for this combined random effect) are, in descending order: Salisbury (in Bath STP), Dartford & Gravesham (Kent), University Hospital of Leicester (Leicester), Oxford University Hospital (Thames Valley), Isle of Wight (Hampshire), University Hospital of Southampton (Hampshire), South Devon Healthcare (Devon), Portsmouth (Hampshire), and Taunton & Somerset (Somerset). These 10 overlap, but are not identical with those having the highest number of alerts, shown in the Parliamentary Report [2, p.4].

What lies behind the unexplained higher risk, particularly in southern England? Could it be a greater proportion of elderly patients, inadequate staffing levels, a relative lack of community provision, transport problems? In the biggest urban areas of London, Birmingham and Manchester, hospitals have comparatively few alerts. On the other hand, Cheshire & Merseyside has nine non-specialist adult Trusts with Type 1 A&E, with five such hospitals on Merseyside and Warrington, which had the highest number of alerts in northern England.

It's clear that bed occupancy, particularly the average occupancy across the STP, is a key risk for alerts. High bed occupancy reflects growing demand, problems with Delayed Transfers of Care, but also lower bed capacity, in turn caused by decisions when hospitals were rebuilt with fewer beds (presumably reflecting the cost of PFI schemes).

High bed occupancy also risks cross-infection. All the more disturbing then that the bed occupancy target has been relaxed by NHS

England and NHS Improvement from 85% to 92% in their own review of Winter 2016-17 [5]. As Royal College of Emergency Medicine president Taj Hassan told the Health Service Journal [6]:

"It is extremely concerning that one recommendation seems to revise the safe level of bed occupancy up to 92 per cent. [The college] would have serious concerns about this as a metric of safety and we would be interested in understanding the evidence base behind this thesis. Our strong view is that the evidence base all points to 85 per cent as being the safer [and more efficient] level that all systems should be aiming for."

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Into the Red Zone

A new briefing for MPs and councillors spells out the dangers

Keep Our NHS Public has produced *NHS Crisis: Into the Red Zone*, a briefing paper [1,2] for MPs, councillors and health campaigners in England, on the crisis facing the NHS in the period immediately following the June 2017 election.

KONP is asking campaigners to share the briefings's executive summary (which should be read in conjunction with the main briefing paper to gain the fullest understanding of the quite substantial detail gone into [3]) with their local MPs, local authority scrutiny leads and councillors.

The briefing covers all aspects of the threat to the NHS and is divided into sections addressing each specifically.

Post-election 2017: new NHS threats

The summary's introduction lists these succinctly:

- Sustainability and Transformation Plans contain disguised cuts equivalent to £22 billion in annual health funding by 2020/21.
- The Capped Expenditure Process (CEP) imposed on 14 STP areas is leading to further dangerous cuts.
- The crisis in NHS staffing vacancies is worsening by the day.
- NHS performance outcomes are missed and targets relaxed – with very real impact on patients.
- There has never been a time when it has been more urgent and important for MPs and local councillors to raise demands with government.

Capped Expenditure Process

The summary defines this with the telling

phrase, 'this bullying must be challenged now'.

Fourteen STP areas are being subjected to the Capped Expenditure Process (CEP), a new rigorous regime developed behind closed doors during pre-election 'purdah', which imposes threats of special measures on any STP area within which any one trust or CCG has not signed off its financial control total. In those 14 areas, senior NHS managers have been told to "think the unthinkable," including "changes which are normally avoided as they are too unpleasant, unpopular or controversial".

Despite some dilution of initial plans in the face of growing opposition (including from prominent Conservatives), the CEP target for savings (originally £470 million) remains a still daunting £250 million by March 2018.

Naylor Review

The Naylor Review threatens massive sale of up to £5 billion NHS estate assets and has been likened to 'a car boot sale of NHS land' to make a quick, one-off profit to boost NHS coffers, while taking no steps to ensure the land – sold to private developers – is developed for anything other than privately owned and sold housing.

The summary goes on to explain:

"The Naylor Review recommends the enforced sale of supposedly 'under-used' and 'surplus to requirements' NHS estates assets. During the general election, Theresa May committed to using NHS estate sales as a major part of her NHS financial plan. She endorsed plans laid down in the Naylor Review to speed and enforce the sell-off. 'Project Phoenix' incredibly is a linked scheme to borrow new private finance to fund developments aimed at increasing the potential market value of the NHS assets being sold.



“Sale proceeds could be used to offset the revenue deficits of NHS trusts – literally selling off the assets to pay the bills. But NHS public assets have been built up over decades and centuries – once sold, those resources will be lost forever. And through ‘Project Phoenix’, the NHS is saddled with escalating private finance contract repayments for 30 years.

“These plans make no sense. The NHS publicly owned estate is needed for urgent new hospital capacity, better patient and staff car parking, affordable housing for NHS and social care staff, intermediate care provision, mental health inpatient and day-care capacity, primary and community care provision.”

Symptoms of the growing crisis

These are described as ‘red alert’:

- Only 28% of trusts have secured a commitment from their local authority (given the LAs’ own severe difficulties) that the extra social care funding will be used to directly reduce ‘delayed transfers of care’ (DToCs) hospital to community care, and thus ease NHS capacity.
- Only 18% of trusts believe they have a commitment sufficient to reduce DToCs to the NHS mandated maximum of 3.5%.
- 64% of trusts report a lack of ambulance capacity.
- 71% a lack of acute capacity.

- 76% a lack of community capacity.
- 80% a lack of mental health capacity.
- 91% a lack of social care capacity and
- 92% a lack of primary care capacity.
- 40,000 nurse vacancies (RCN, May 2017) undermine patient safety and quality of care...
- ... yet Jeremy Hunt is planning to privatise NHS Professionals, the NHS’s own locum agency, which has saved the NHS £77 million last year alone. Hunt’s intentions are clearly ideological.
- 15,000 beds lost since 2010 – 9000 acute; 6000 mental health and learning disability ...
- ... yet major reconfigurations, closures and mergers threaten tens of thousands more beds and jobs.

Are there positive points to STPs?

The briefing makes this a plain ‘no’:

“The avowed task of STPs is to drive through cash savings which CCG commissioners would not be able to achieve alone. Any positive potential is completely outweighed by the damaging financial context, the trajectory of, secrecy over and lack of consultation on the drastic agenda of the STP programmes.”

Accountable Care Systems (ACSs)

The summary stresses that, while posing as local bodies, these in fact **strengthen** central control:

“ACSs is imposing on all of the commissioners and providers in an area a cash-limited budget – one grossly inadequate to meet the needs of the local population. Each ACS will be expected to be ‘more assertively moderating demand growth’ and will face ‘stringent quality, finance and governance demands’, facing strong

measures should efforts to deliver universal, equitable and safe care prove incompatible with meeting the imposed cash limit.’”

An illuminating comparison with the US experience is explored in the full briefing.

Commonwealth Fund findings

The weaknesses of depending on the Commonwealth Fund's latest findings [4], which has found the NHS to be best amongst the 11 nations' health systems. it compares, are spelled out. Critically:

“Where the NHS comparatively fares worst once again is on outcomes. Health outcomes are affected by many factors, including social exclusion, poverty, inadequate housing, poor education and the resulting health inequality.

“Lack of significant investment in primary health care and problems of access to increasingly centralised services are almost certainly factors in late detection of health problems.”

Support for the NHS Bill

In summing up, the briefing and summary are unequivocal in their support for the NHS Bill:

“The competitive market created in healthcare in England is the driving force behind the replacement of professionalism by managerialism, the wastage of £ billions annually and a change in the core ethos of the NHS. Cooperation has been replaced by competition. STPs cannot overcome this. Moves to better integration have been

halted by the disintegration brought in by the Health & Social Care Act, unfunded uncoordinated devolution and the break-up of the NHS.

“Legislative reform is essential to scrap the market, restore professionalism and recapture the integrity and values of the NHS. The NHS Reinstatement Bill (www.nhsbill2015.org) ... offers a coherent approach to restoring the NHS to its pre-Thatcher form, before the ‘internal market’ and contracting out of support services.”

MPs, councillors and health campaigners are urged to act now to save the NHS, and several

recent examples of successful concerted local action are given.

NHS Crisis: Into the Red Zone is written by Dr John Lister, co-chair of KONP and editor of *Health Campaigns Together*, and is available as a fully referenced text version [1] and in magazine format [2]. The executive summary [3] is also available.

“The competitive market created in healthcare ... is the driving force behind the replacement of professionalism with managerialism ... and a change in the core ethos of the NHS.”

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Health Campaigns Together

● Defending Our NHS ● www.healthcampaignstogether.com ● @nhscampaigns ● FREE

Health Campaigns Together continues to flourish, and is attracting an increasing number of local and national health campaigns and trade union branches to join forces and coordinate joint events to bring the dangers to the NHS into the public eye. DFNHS was a founding member 2 years ago.

HCT's quarterly 12-page newspaper now boasts a regular circulation in excess of 12,000: no mean feat for a paid-for quarterly (although prices are kept low to cover production and postage costs).

The next issue (Number 8) will be published in the first week of October.

In between now and then a special 4-page A4 edition will be produced for use at events around the Labour and Tory Party conferences.

You can submit articles, pictures, news cuttings and ideas for the newspaper to the editor John Lister (johnlister@healthemergency.org.uk) or the assistant editor Alan Taman (healthjournos@gmail.com) by Monday September 25.

Major conference

HCT is holding a major conference on what NHS campaigning groups can do next.

Our NHS and Social Care in Crisis – Fighting Back to Win will be held in London on Saturday 4 November.

The aim is to hold "the biggest-ever national campaigners' conference to broaden, deepen and strengthen campaigning all over the country. We have a weak and wobbly government attacking our NHS: so let's push them and make them wobble or fall over!". Conference themes are:

- End the freeze on NHS spending.



- Scrap the cap on NHS pay.
- No cuts or cash-driven closures.
- No privatisation.
- For a publicly funded and publicly provided NHS and social care.
- End the competitive market in health care.

The speakers will be drawn from trade unions, local government and campaigners. Those already agreed include Sara Gorton (Head of Health, UNISON); Sarah Cook (Unite the Union), and two council leaders who have refused to comply with their STP and are fighting threats to their local hospitals: Cllr Steve Cowan (Hammersmith & Fulham) and Cllr Julian Bell (Ealing).

The majority of time is set aside for workshops, collaboration and discussion.

Lunch is provided for pre-booked delegates.

HCT will contribute towards costs of long distance public transport from the North, Devon and Cornwall.

Early bird fee £7.50 (£5 concessions), late booking/ on door £10 (£7.50 concessions).

Venue: Hammersmith Town Hall, London W6 9LE (nearest tube: Hammersmith). Saturday 4 November. 11 am to 4 pm.

Details : www.healthcampaignstogether.com

Online booking: (via Eventbrite):

<http://bit.ly/2v4jJC0>



Talk NHS: a public debate on the past, present and future of the NHS

On 19 August the Royal Society of Medicine hosted a one-day debate on the NHS, culminating in a keynote speech by Professor Stephen Hawking in which he roundly criticised the government's current treatment of the NHS and privatisation. Eric Watts, DFNHS Chair, gives his interpretation of the day; followed by John Puntis, Secretary of Keep Our NHS Public

The opening section of the conference started by asking 'What is the state of the NHS?'

Sarah Woollaston (Conservative MP and Chair; Health Select Committee) started by saying the fundamentals of the NHS are sound and that she was proud of this great British achievement. Funding had fallen – from around 4% long term to 1.1% increase in the last 7 years. She did say that she did not want a US style service and when challenged on this said if such plans became party policy she would resign. She added that the NHS needs more funding and it should be 12% of GDP.

Ruth Allen (social worker) spoke of the need for more integration between NHS and social work, and reported that half a million more people now no longer receive benefits than in 2010.

Liz McNulty of the Patient's Association (who previously worked as a nurse) spoke of increasing rationing and the underfunding of social work leading to people staying longer in hospital as social care packages cannot be organised to allow them to go home; she quoted a nurse reporting that they had to explain themselves to managers if they had a patient kept in hospital for more than 5 days.

Rachel Clarke spoke of her ambition as a young doctor; driven by the pursuit of excellence and how it had been frustrated by problems of workload and insufficient team support – at the beginning of her career there was a real 'firm' or team atmosphere – now the situation too often is that she's a shiftworker with no ready support. She found it hard to believe that the government cared about the working conditions of junior doctors. She went on to say that the staff are the greatest strength of the NHS (see also book review, page 27).

All speakers agreed that the NHS exemplifies simple good decent values that must be preserved. Most speakers said STPs could be made to work but there was too much secrecy and insufficient funding.

In section 2 – which posed the question 'How did we get here?' – Nigel Edwards (Chief Executive of the Nuffield Trust) said a major problem of the NHS was its size and that units dealing with 1-5 million would be better; and that privatisations are generally done wrong. He also stated that specialists had become over-specialised (probably copying the private sector).

Clare Gerada (former chair of the RCGP) celebrated the NHS 70th year stating it is part of our national identity. She agreed that over-



DFNHS Chair Eric Watts (right) and KONP Co-chair Tony O'Sullivan at the conference

specialisation yielded worse outcomes than generalist care. She spoke of the difficulty in speaking truth unto power and in particular her difficulty in opposing the 2012 Health and Social Care Bill – that she was president elect of RCGP then and went to the USA (at her own expense) to see how the Bill's proposals worked in practice. She found that many US citizens had poor levels of care. But she had found it hard to get the point across that the Bill could disrupt and fragment the planning processes in the NHS. Her take on this was that most people found it difficult to accept that those in power could 'get it wrong'.

The third section, chaired by SNP MP and DFNHS member Philippa Whitford, turned to considering what to do next.

Neen Modi (President, RCPCH) said that much is good in the NHS. NICE was the best way(yet) of bringing in 'fairness'. The discussion considered the 'civilising' effect of the NHS, and that it was up to us to keep the momentum. There was also a call for more cross-party collaboration and to break down parliamentary tribalism.

Parting smile

Stephen Hawking's keynote speech was brilliant. At one point he was 6 feet from me – I managed to resist a selfie! His medical journey began with a fall in 1962. In 1975 Swiss doctors recommended they switch off the ventilator but he was flown back to UK. Pneumonia ++ pre laryngectomy. He was told by a UK doctor he was going home to die so he changed his doctor! Lots of excellent care in NHS although he sometimes had to look for it. Best feature is no financial constraint if a doctor recommends treatment. He had experience of inefficient privatised services. As a physicist he can see forces at work and too much power in the hands of companies seeking profit.

On his closing statement, calling to bring back the NHS, there was warm applause and a standing ovation – you could just see his lips move into a smile.

Eric Watts

A wide range of speakers from different disciplines were invited; the audience provided lively questions and commentary.

Speakers recognised that the important fundamental principles of the NHS were under huge pressure from rising demand, workforce deficiencies, and underfunding. The importance of integrating health and social care was emphasised, with the role of social work including a focus on the needs and rights of citizens at a time when austerity was undermining social justice and half a million fewer people were able to access adult social care than just a few years ago.

Although the NHS is staffed by dedicated and compassionate workers, the current requirement to deliver £22 billion in savings is making it impossible for them to deliver a quality service. With 6,000 too few doctors and 40,000 nurse vacancies in England, staff are increasingly demoralised by being unable to deliver the quality of care to which they aspire, a situation exacerbated by a government in a state of denial.

Sarah Wollaston insisted that Simon Stevens is keen to move away from the internal market, and would like to end wasteful contracting rounds in favour of area based commissioning. However, she did not believe that we were moving to an insurance based system, but were in fact retreating from privatised care. Other speakers and members of the audience were quick to point out that statistics show the precise opposite, with increasing involvement in the NHS of private companies, and new contracts for Accountable Care Organisations clearly expected to attract large international private providers. Louise Irvine, Chair of Health Campaigns Together, pointed out that the government was not seeking to repeal the Health and Social Care Act with its mandate for competition actively encouraging further privatisation.

Tony O'Sullivan, co-chair of Keep Our NHS Public, commented that there would be £40

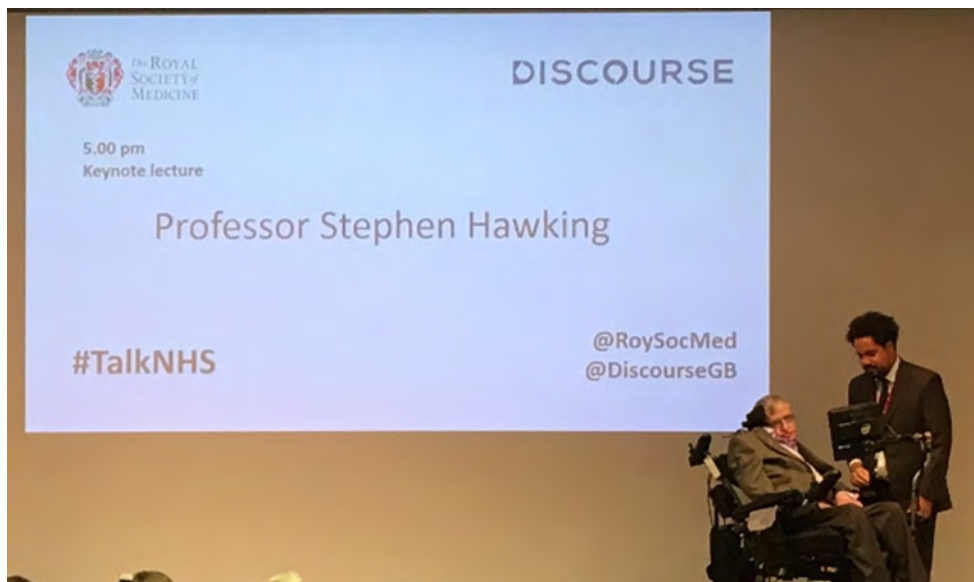
billion extra a year for health care if we spent as much as some other European countries, and that the 30,000 excess deaths highlighted in a recent study from Oxford was an outcome measure of the effects of austerity in the UK. In contrast, the US Commonwealth Fund report (although favourable to the NHS) was based on a survey of opinions, and actually indicated that death and morbidity outcomes for the NHS are relatively poor. It was therefore unacceptable for Jeremy Hunt to seize on this report as evidence that his leadership has made the NHS the best health care system in the world.

Wendy Savage (President of KONP) added that Oliver Letwin and John Redwood articulated the Tory party position on the NHS as far back as 1988 by enthusiastically promoting privatisation, a philosophy subsequently echoed by Jeremy Hunt.

Claire Gerada castigated those who had not stood up against the Health and Social Care Bill, who, out of fear or ignorance, had colluded with politicians in the naïve belief that those in positions of authority must be right. Richard Murphy, a political economist, said that the NHS was a practical manifestation of our inbuilt empathy and the fruit of a post-war political will to utilise Keynesian economics in the transformation of society by spending.

The neoliberal philosophy that markets are always the right mechanism for distributing resources is a core philosophy of the Tory party, and some other parties, and since 1980 achieved dominance in the NHS. There is no economic reason for austerity, since the government can print money without limit and claim it back by taxation. Shrinking the size of the state is a key neoliberal principle; organisations are then set up to fail as this is fundamentally necessary to operating a market. The NHS we have is the result of political choice, and a publicly funded NHS is counter to market interests and hence the target of neoliberals.

The keynote speaker of the day was Professor Stephen Hawking. His speech had already been



publicised and drawn savage criticism from Jeremy Hunt who urged Professor Hawking to “examine the evidence” and desist from spreading “pernicious falsehoods”. Professor Hawking gave a moving presentation in defence of the NHS, outlining his personal experience of care and his interest beyond this in protecting a service that represented a civilised society. He reflected that his survival in the face of serious illness would not have been possible if it were not for the NHS.

Professor Hawking took issue with Jeremy Hunt over 7 day working while conceding that this might be of benefit to patients. He went on to emphasise that policy making should be based on evidence, so that “any change like this must be properly researched. Its benefits over the current system must be argued for; and evidence for them presented; and the implementation must be properly planned and costed and the necessary resources provided.... Hunt has cherry picked research. Speaking as a scientist, cherry picking research is unacceptable. Citing some studies and suppressing others to justify policies that they want to implement for

other reasons debases scientific culture.”

He also raised concerns about increasing privatisation, stating: “When politicians and private healthcare lobbyists claim that we cannot afford the NHS, this is the exact inversion of the truth. We cannot afford not to have the NHS. A publicly provided, publicly run system is the most efficient and therefore more cost effective way to provide good healthcare to all.”

In considering what might be done about the present state of affairs, Professor Hawking said that the direction of travel will depend on the relative strength of different forces acting in pursuit of conflicting interests. The multinational companies are driven by profit motive, and the direction of travel currently in the UK is towards a US type insurance system as the balance of power now lies with private companies. On other side is the force of public opinion and democracy, with polls showing that the public agree with his concerns and continue to support the core principles of NHS. This provides hope for the future.

John Puntis

BMA ARM 2017: Dare to hope?

The BMA's Annual Representative Meeting, held from 26 to 29 June, contained motions on a wide variety of subjects. This article picks out those of importance in the fight to defend the NHS from privatisation.

Motion 42 calling for the abandonment of Sustainability and Transformation Partnerships (STPs) was overwhelmingly voted through on Monday, lifting the spirits of those aiming to commit the BMA to defend the NHS as a public service.

On Thursday, the passing of two 'chosen motions' – opposing charges to see the GP and for social care to be publicly provided like the NHS – confirmed the ARM's opposition to a privatised health and social care system.

ARM again won a victory against the view of the heads of the consultants committee when it voted in favour of the BMA organising a ballot on Hunt's new proposed consultants' contract.

Mark Porter, chair of Council, in his opening speech condemned the dire lack of NHS funding and described the desperate shortages of beds and staff in hospitals, mental and public health and general practice and slammed 'picking the pockets' of NHS staff.

In relation to the key onslaught on the NHS in the last year – the secret setting up of 44 STPs by NHS England, to cut and privatise the NHS by 2020 – he said the following:

"For how can they be sustainable when they are forced to find £26 billion of cuts in health and social care? How can they bring about seismic transformation when they need £10 billion of investment just to get off the ground?"

Thus, he re-stated the BMA's position of deploring the lack of funds to make STPs work properly, rather than opposing their creation as instruments to finish off the NHS.

The incoming chair of Council, Dr Chaand Nagpaul (erstwhile chair of the General

Practitioners Committee), made no mention of STPs in his speech. Yet these STP boards are busy running down general practices.

Motions on STPs

Two motions were presented on STPs.

Agenda Committee (AC) Motion 41 read: "That this meeting believes that sustainability and transformation plans have not produced a sustainable funding model for the NHS in England, and the BMA calls for: (then seven demands ending with)"(viii) STPs to be fully funded to achieve true transformation." The mover made clear that the motion was about "staying in the tent."

In the debate consultant Kevin O'Kane said: "We are being asked to take part in critical engagement STPs are vehicles to make £22 billion of cuts.... They're about closing services and easing in private providers. We would be 'discredited facilitators' if we got involved." Jacky Davis, Council (and DFNHS member), said: "Critical engagement did not work for the Health and Social Care Act". The motion scraped through with some button votes.

AC Motion 42 stated: "That this meeting condemns the woeful manner in which STPs have been progressed, turning them into vehicles to try to legitimise further cuts to vital NHS services, and proposes STPs are abandoned."

Mrs Anna Athow, speaking on behalf of London Regional Council, outlined the way the new 44 STP boards were fulfilling the objectives of the *Five Year Forward View* (FYFV) already, by making sweeping cuts to A&Es and entire hospitals, rationing and denying services to millions of patients, selling off NHS assets and cutting the pay bill through reducing and downgrading staff. STP boards were NHS England's new tools



to carve up our national NHS into 44 semi-devolved administrative fiefdoms instructed to shift funds out of NHS services and into the new privatisation models of the FYFV such as hospital chains, and MCPs (Multispecialty Community Providers) – gigantic health and social care hubs designed for corporate running for profit as huge public-private partnerships.

She ended: "We don't want American style healthcare in England". The motion was overwhelmingly passed.

General Practice

The GP section of the agenda reflected the devastation going on in General Practice.

Dr Nagpaul's speech dwelt on the diminishing number of GPs, due to their impossible workload and massive underfunding.

His position on the reforms was contradictory. He said that GPC had accepted multi-professional working and that patients could see pharmacists and others instead of GPs. He was in favour of working "at scale" in federations and super-practices, and "managing demand". This implied going along with the primary care hubs of the FYFV, which he did not mention.

On the other hand he said: "It is vital we support each other as one GP profession, since if the partnership model collapses it will sink the entire profession in the process, with the risk

that all GPs will in the future be at the mercy of working for large commercial providers, who are likely to have values and an ethos at odds to everything we stand for."

The meeting supported motion 69 which instructed the BMA council and GPC to construct a system for declaring "black alerts" for GPs to indicate when maximum safe capacity had been reached, to act as a defence for GPs in the face of GMC criticism for inadequate performance.

Motion 70 expressed concern about contracts for GPs in the 'new model' MCPs:

"That this meeting feels that the Multispecialty Community Provider contract framework does not go far enough in

(i) protecting the liability of the individual contract holders from the implication of pooled budgets.

(ii) preserving the tenure of GMS and PMS contracts

(iii) protecting GPs from further unfunded work being transferred from secondary care"

In supporting the motion, Dr Nagpaul made the point "that MCPs move the national contract to "a local time limited contract, which could be put out to commercial contract after

that."

In other words the current life-time NHS GP contracts which GP partners have (GMS and PMS) would be abolished.

The GP section did not include any calls for action to defend general practice.

In May 2017 the GPs LMC conference had passed the following AC motion: "That this conference instructs the GPC to produce a discussion paper outlining alternative funding options for general practice, including co-payments."

It was important, therefore, that chosen motion 362 from NW Regional Council was

"STPs are vehicles to make £22 billion of cuts....They're about closing services and easing in the private providers."

overwhelmingly passed by ARM. Moved by David Wrigley, Deputy Chair of Council, it stated: "That this meeting opposes charges for patients; (i) to see a GP (ii) if an appointment is missed." He said charges discourage the poor and disadvantaged from getting the care they need. Junior Doctor James Haddock, said: "Charges are unfair and lead to health inequalities. This motion is a reaffirmation of our NHS."

Condemning NHS crisis

On Monday, motions were passed condemning the crisis in the NHS, the lack of funding, and doctor burnout from overwork. Calls were made for an occupational health service for staff, for the BMA to lobby the GMC to take into account system failure, and better workforce planning for shortage specialties. Motions called for abolition of staff car park charges, better wages for care workers and the abolition of referral management systems.

Two motions went through which appeared to accept that extended role practitioners (ERPs) such as physicians associates, were here to stay as doctor substitutes.

Integrating health and social care

AC Motion 12, proposed by Scottish Council contained dangerous proposals; (i) "called for support for the principle of the integration of health and social care" and (v) called for an open discussion about what services could and could not be provided on the NHS given lack of funding.

Louise Irvine, Council, spoke against (i) on the grounds that in England healthcare was free at the point of use and social care was means

tested, whilst in Scotland personal social care was free. To accept (i) in England she said "would erode away the NHS" and to accept (v) would imply that the public was in favour of rationing. Unfortunately the motion was passed.

It was important therefore that "chosen motion" 37e was passed later in the week, as it showed that ARM did not want means testing of health or social care. The motion moved by Steve Watkins of North Western Regional Council read: "That this meeting calls for social care to be available free at the time of need, financed out of general taxation and provided as part of the comprehensive health service."

The agenda committee managed to avoid

taking any emergency motions, including one expressing support for the Serco workers at Barts/ London.

"This meeting calls for social care to be available free at the time of need financed out of general taxation and provided as part of the comprehensive health service."

Policy opposing privatisation

The main message of this year's ARM was that a large body of doctors are opposed to the government's privatisation reforms, and that official

policy of the BMA has been altered to reflect this.

The task now is to take these forward into the wider trade union and labour movement and fight to defend and restore our NHS as a properly funded and publicly provided service.

In line with this, the London Region Executive on 25 July proposed to organise a demonstration in London against STPs and the Capped Expenditure Process, and sent a message of support to the Serco Barts /Health workers.

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Book Reviews

Your Life in My Hands – A Junior Doctor's Story

Rachel Clarke, Metro Publishers, 2017

288pp. Hardback £13.99, Kindle edition £6.64

Rachel Clarke comes from several generations of doctors and is now a junior doctor working in palliative care but before entering medicine read PPE at Oxford and spent 10 successful years as a television journalist.

This very readable book begins with a terrifying account of her hiding in a UN compound while under fire, in a civil war in the Democratic Republic of Congo, expecting at any moment to be raped, killed or both. Even this, she felt,

was less alarming than her first nights on call as a brand-new doctor. Only a very fortunate few will not remember the long hours, the feelings of inadequacy and the difficulty with procedures that would soon become routine, but the relentless and often overwhelming intensity of work, well described by Dr Clarke, is relatively new. The effects and implications of understaffing are a major theme in this book. Junior doctors are frequently on call for far more patients than they can reasonably cope with. This is all too often made much worse by rota gaps, now common

in almost all hospitals, when the doctor has to cover an absent colleague's work as well as his or her own. Constant bed shortages cause impossible overcrowding in A&E while ambulances queue up outside. We read about a seriously ill child with peritonitis who would

probably have died if the consultant surgeon had not defied the managers who absolutely insisted that there were no beds and he must be sent elsewhere.

The Francis Report on Mid-Staffordshire was published in Dr Clarke's first year as a doctor; but while she was still a medical student her grandfather, himself a retired NHS GP and then in his nineties, had died in hospital after apparent neglect by ward staff. Once qualified, Dr Clarke realised how frequent nursing

“Junior doctors’ morale is a significant theme in the book and Dr Clarke describes times when her friends and colleagues have been close to despair because of exhaustion and the overwhelming demands of their jobs. Some, sadly, have given up medicine altogether.”

shortages can make poor care unavoidable and that even normally kind, caring and professional people can gradually come to accept inadequate care as the norm. If staff are impossibly busy, kindness and the time to talk to patients inevitably suffer. This very much damages morale as staff feel they cannot do their job properly. A very competent but exhausted ward sister bursts into tears when her Trust tries to improve morale by offering Zumba classes during the ‘lunch hour’, evidently quite unaware that a lunch hour was but a distant dream for most clinical staff.

Dr Clarke is a scathing critic of Jeremy Hunt. As a journalist she met numerous senior politicians and this has helped her to recognise the tactics he used during the junior doctors' dispute, his use of propaganda and his distortion of statistics. Mr Hunt claimed that 11,000 patients

a year were dying because they were admitted at weekends, implying that consultants were too lazy to do any weekend work. Dr Clarke points out several times that when she was in hospital at weekends, her consultants were there too. Jeremy Hunt then promised the public that hospitals would provide full services 7 days a week, but said this would be achieved in a cost-neutral way, raising suspicions among junior doctors that they would be working more at weekends but this would result in inadequate care during the week. Having attacked both consultants and junior doctors, he then attacked GPs for being too lazy to work from 8am to 8pm every day, thus achieving unity across the whole profession.

The BMA does not come out well from the junior doctors' dispute. Unfortunate leaked e-mails suggested a secret strategy to drag it out and also stated that weekend pay was the major issue even though this was certainly not the case for Dr Clarke and her colleagues.

One of the real problems with the new junior doctor contract was that, although the basic salary had been increased, payment for out of hours work was significantly less. An equality assessment showed that this would unduly penalise female doctors, but Mr Hunt apparently considered this a price worth paying. Dr Clarke, whose son was born while she was still a medical student, found that the expense of frequent out of hours child care meant that, even though she was working extremely hard, she made a net loss of £5000 a year. She normally arrived home several hours late so the child care had to extend well beyond her official working hours, but her extra work was of course unpaid.

Junior doctors' morale is a significant theme in the book and Dr Clarke describes times when her friends and colleagues have been close to despair because of exhaustion and the overwhelming demands of their jobs. Some, sadly, have given up medicine altogether.

Some things which contribute to poor morale are surely unnecessary and must be dealt

with. Many Trusts, it appears, expect doctors to start work before they have signed their employment contract and without knowing what they will be paid, when they will be on call or even sometimes which town they will start work in. Annual leave dates may be imposed without consideration for the individual's wishes or family circumstances, making it almost impossible to plan for important events, even in one case for the doctor's own wedding. This must be unreasonable. Throughout the book the importance of colleagues is obvious, but the loss of the hospital 'firm' means that the doctor is no longer part of a close-knit team as in the past and has much less contact with individual consultants.

In spite of the intensity of work, the problems with politicians and the financial strain on her family, Dr Clarke is clearly passionate about the NHS and about her profession. She gives some moving vignettes of patients she has cared for and also of the inspirational role of those consultants who, in spite of their own pressures of work, are enthusiastic teachers.

I hope this book will be widely read, not only by doctors but also by journalists and others who may be critical of patient care and may too easily blame staff who are doing their very best in impossible circumstances. Hospital managers, and those in charge of rotas, should read it and think carefully about steps they can take to give junior doctors the information they need before beginning a post and must allow reasonable arrangements for annual leave. All of us need to encourage, teach and support our junior colleagues and Rachel Clarke shows us how vital this is.

I doubt if he will, but Mr Hunt should certainly read this book.

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Dismembered. How the attack on the state harms us all

Polly Toynbee and David Walker, Guardian Books, 2017

330 pp. Paperback £7.99, Kindle edition £6.47

Mary Louisa “Polly” Toynbee is a British journalist and writer and has been a columnist for the *Guardian* newspaper since 1998. David Walker is a contributing editor to an off-shoot of the *Guardian* called the Public Leaders Network. According to Wikipedia, they are married to each other.

The theme of this book is that neoliberalism results in shrinkage of the state, deregulation and privatisation, and that the market provides services poorly. The market fragments services; austerity is used as an excuse for downsizing the state; and short-term profit diminishes investment in the service. The idea that the private sector is more efficient than the public in provision of services is examined. The book describes many examples of how the private sector has performed unacceptably.

Politicians promoting austerity try to frighten voters with the scale of the national debt. In 2016–17 the UK expenditure of £772 billion included an over-spend of £56 billion. The national (longstanding) debt was £1,638 billion in March 2017. It works out that each of the UK's 65 million persons shares £25,200 of the national debt, but that the average individual wealth is £135,000 which is five times as much. The authors point out that when a family takes on a house mortgage, the comparable ratio of debt to income can be comfortably managed over 30 years.

In the period 2010 to 2017 public spending as a proportion of GDP fell from 45% to 39%. The Cameron/Osborne plan, not renounced by May/Hammond, is to lower public spending to 36% by 2020–21. The current figure for Germany is 44%. Just after the 2015 general election Toynbee had written in the *Guardian* that the pain of austerity would fall in the period before 2020 when the electorate would not be able to respond, but the unexpected 2017 election was just such a chance. Cuts to schools,

hospitals, community centres, libraries etc no doubt contributed to the election result. The authors write that the state already has a smaller presence than at any time since the early 1960s. Government employment will have fallen by 1.1 million between 2010–11 and 2018–19.

The authors mention the introduction of New Public Management (NPM). Wikipedia provides more detail, that NPM is an approach to running public service organisations that was developed in the 1980s under Mrs Thatcher. The term is used to describe approaches that were developed as part of an effort to make the public service more “business-like”, ostensibly to improve its efficiency by using private sector management models, and to reduce costs. The NHS was an early recipient of NPM. Quasi-market structures made the public sector compete against the private sector. Key themes in NPM are financial control, identifying and setting targets, continual monitoring of performance, handing over power to senior management and pay-for-performance. Performance is assessed with audits, benchmarks and other evaluations. NPM removes collective agreements in favour of, at senior level, individual rule, with reward packages combined with short-term contracts. It introduces private-sector style corporate governance (eg NHS Trusts). In this context managers have greater discretion and freedom as to how they go about achieving the goals set for them, with less emphasis on consultative collaboration. While NPM approaches have been used in many countries around the world, NPM is particularly associated with the most industrialised OECD countries such as the UK, Australia and the USA.

Contracting out government activities to private companies has relied on the belief that the firms do the job better. At present contracting accounts for one pound in every three of total government spending. In 2014–15

the public sector bill for private and voluntary sector suppliers was £242 billion, considerably more than was spent on the in-house staff (£194 billion). There are large companies whose main business lies within the public sector – the Big Four are Capita, Serco, G4S and Atos. They have lawyers expert at ticking all the boxes in bidding for tenders and snap up contracts for services of which often they have had no prior experience. During the Cameron era these companies won nearly every central government contract on offer. Yet they do not have to conform to public sector norms of accountability, nor conditions and pay for their staff. By contrast, the state is rife with self-reporting and a rottweiler approach is used to undermine public confidence in public provision. The authors write that this has been the stock in trade of Jeremy Hunt.

Serco's provision of the out-of-hours GP service in Cornwall resulted in a report from the House of Commons Committee of Public Accounts [1]. It stated that in early 2012 whistleblowers raised concerns that the out-of-hours service in Cornwall was short staffed and that the contractor, Serco, had lied about its performance by altering data. The primary care trust and the strategic health authority did not demonstrate that they had the appropriate skills to negotiate effectively with private providers and hold them to proper account for poor performance.

Evidence confirmed that what the whistleblowers in Cornwall had said was substantially true. However, Serco had had a bullying culture and management style which inhibited whistleblowers from being open in the patients' interest.

The company responded to stories placed in the press by whistleblowers in a heavy-handed way, launching internal investigations and even searching employees' lockers. Staff were fearful of raising concerns. Serco initially denied the whistleblowers' concerns and it was only after reports appeared in the press that it started to accept that things had gone wrong. Most concerning was the fact that Serco staff

altered data on 252 occasions, resulting in Serco overstating the performance it reported to the primary care trust. Serco conceded that the contract manager had been paid a bonus which was linked to the reported performance. Serco had struggled to ensure enough staff were available to fill all of its clinic and domiciliary shifts. Serco's performance declined dramatically in the middle of 2012 and the primary care trust did not detect this. When these issues did come to light, it did not penalise Serco, withhold payment or terminate the contract. At the time the contract was set in 2011, Serco was one of only two bidders. Other potential bidders dropped out as they could not stay within the cost ceiling set by the primary care trust. Serco continues to win large government contracts.

Many other, and more up-to-date, examples of private sector performance are given.

Michael Meacher's *'The State We Need'* [2] gives a wider perspective than *'Dismembered'* of the problems of neoliberalism and their solution. Meacher's cogent, well-referenced book remains highly relevant despite its 2013 publication date. Toynbee and Walker are bang up to date with, for example, issues to do with Mrs May's premiership.

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Saturday October 7th 2017

Bedern Hall, Bartle Garth, St Andrewgate, York YO1 7AL

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with evening meal

Full details and application forms should be with members by mid-September.

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