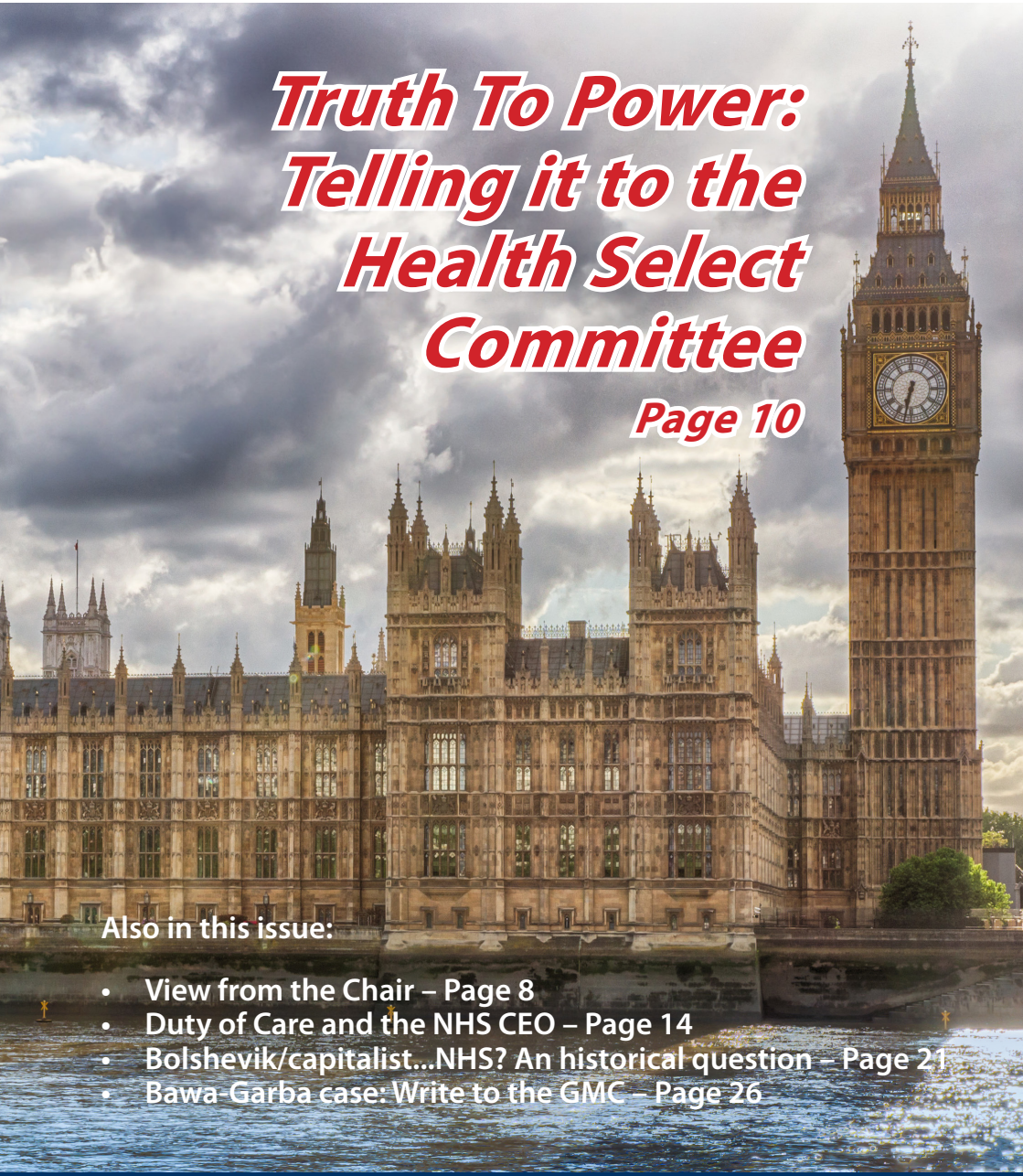
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER



Truth To Power: Telling it to the Health Select Committee

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Keep Telling it the Way it is

Now, more than ever, we need to re-affirm the founding principles of the NHS. As our committed NHS staff struggle under increasing difficulties the performance figures show a poor response from government. As the consensus view of experts predicted before the November budget, without adequate investment the service deteriorated.

The Quarterly Monitoring Report shows that in January, the number of patients waiting for more than 4 hours after a decision to admit them to hospital from A&E (trolley waits) rose to 81,003, with 1,043 waiting more 12 hours – both the highest on record. These patients are usually waiting for a bed in hospital and are most in need of treatment.

Public satisfaction with the NHS overall has dropped sharply in the past year and dissatisfaction is at its highest level since 2007. The British Social Attitudes Survey showed a sharp drop of 6% in public satisfaction with the NHS, down to 57%. The four main reasons that people gave for being dissatisfied with the NHS overall were: staff shortages, long waiting times, lack of funding, and government reforms.

It is extraordinary that thousands of operations were cancelled at short notice, making it appear that winter pressures came, unexpectedly out of the blue. Government policy, when events turn for the worse, appears to be to blame anyone but themselves.

Did winter come as a surprise this year? No, like previous years it followed Autumn but this year, contrary to their propaganda, the NHS and Local Authority Social Services were poorly equipped having been denied the resources they need.

There is good news amongst the gloom as the Judicial Review of ACO organisations is gaining ground and our colleagues in Health Campaigns Together have an active programme of meetings ,demonstrations and a 70th birthday celebration to come in July.

Our campaigning in the past has been directed towards the government as they decide policy but this government has turned a blind eye to the simple truth that it is failing to invest sufficiently. The battle for hearts and minds can be hard, whilst we know the NHS has been the envy of the world and its principles are sound we have a constellation of vested interests in an alliance to undermine the service through repeated attacks in the press and creeping privatisation.

The silent majority holds firm as surveys continue to show more than 80% would prefer a better funded NHS and are prepared to pay more tax to pay for it.

The undermining is mostly through endless repetition of the myths that NHS is expensive and inefficient and yet the international comparisons show our service to be the most efficient available.

The Commonwealth Fund and OECD figures also bear out the fact that extra funding gives better performance, showing the UK taking top position in their table after the investment in 2002-2008.

What will it take to shake them out of this complacency? We continue with the two pronged approach reminding the public and politicians that there is a better way whilst reporting that their current efforts simply are not good enough.

Our position is clear, the principles of the NHS are sound. They are built on co-operation in the patient's interest and we see great potential for closer co-operation with social services but we must not undermine the NHS through fragmentation nor by giving up our founding principles.

News Round-up

Over 60,000 people marched on Downing Street on Saturday 3rd February. Health Campaigns Together have an excellent array of photos and video from the day on their website - www.healthcampaignstogether.com

Resistance to ACSs is winning - West Cornwall Healthwatch said it "applauds the decision of Cornwall Council not to press on with its plans to set up an 'Integrated Strategic Commissioning' body or Accountable Care System".

KONP (supported by DFNHS) also has an excellent selection of news - keepournhspublic.com

Health Select Committee Hearings

The Health Select Committee heard evidence about STPs and the first to present were our members, Tony O'Sullivan(KONP C0-chair) our current Chair Colin Hutchinson and previous Chair Alyson Pollock, and Dr Graham Winyard, a previous CMO.

The meeting started with customary pleasantries but the panel showed a distaste for the evidence they were hearing. The panel were aware of the shortcomings of the NHS, they knew about underfunding but they seemed happy to accept that integration was the answer. They did not like the impudent four in front of them explaining that what matters to patients is not the organisational superstructure but the service the patient receives when they need care. One major question remains – how will 'integration' deal with the major difference that NHS care is free and social care means tested? That issue has not been addressed and the panel responded with the line 'We ask the questions and you answer them'.

"The meeting started with customary pleasantries but the panel showed a distaste for the evidence they were hearing"

The Committee members stated that the 2012 Health and Social Care Act gave us unnecessary problems with its emphasis on competition and they clearly favoured 'working around it'. Whilst we agree the 2012 Act was a monstrous blunder we would rather see it gone completely and that 'working around it' could further damage the great strengths of the NHS – a shared sense of purpose to a publicly owned and publicly accountable service.

It was clear that they had been shown a good service at Worksop and had come away so impressed that they believed this is the future, only achievable through the STP/ACO approach and that non-believers should be ridiculed or ignored.

Our group did explain that we want joined-up services and how we would see this – through the NHS Reinstatement Bill – but the panel showed they liked what they had seen and could not think beyond it. Strangely they seemed unaware that co-ordinated health centres were a major part of the original plans for the NHS (Bevan compromised to win over GPs so few were established). Health centres have been part of the NHS landscape for years and we do not need STPs to make them happen.

After some caustic comments from panel members our group's time was up and two more sessions followed with different groups (reps from the BMA, RCN and charities) making remarkably similar points but to a more sympathetic panel. Very relevant pints were made by the charities group that there are many plans for integration and we need to look at the specifics of how they will work (some good some not). At the individual patient level integrated pathways count for little, as working professionals know a patient is an individual and requires treatment that is tailored to their needs.

It is this risk of deprofessionalisation of care that concerns many.

One point all agreed on was that the trust which has been the embodiment of the NHS is becoming very thinly stretched.

Does the NHS Really Need More Money? was the provocative title of a conference run by our Executive member Arun Baksi. This took place in October in association with the *Journal of Innovation in Healthcare* and the British Association of Physicians of Indian Origin. It attracted MPs including Johnnie Mercer, new MP for Plymouth (Con), a new member of the Health Select Committee (HSC); and Sarah Woolaston, the Chair of the HSC.

My contribution was to present the clear evidence that investment in the service brings results.

The evidence of benefit is clear from recent history, quoting from the 2016 LSE report *The Health System in Transition*. Between 1997 and 2008 expenditure on health care per capita increased from £231 in 1980 to £1,168 in 2000, and by 2008 it was £1,852.

Waiting lists halved and people waited less time for treatment. The 1.3 million people on NHS waiting lists in 1998 fell to under 600,000 in 2008. Median average waiting times for elective treatment (eg hip replacements, heart surgery) fell from 12.7 weeks in 2002 to 4.3 weeks in 2010. There is also evidence that, for example, stroke care improved between 2000 and 2009, with a 25% improvement in mortality rates following admission to hospital.

Attendance figures at GP surgeries, a key activity measure, rose by more than a third between the early 1980s and 2005. With increased resources, the NHS was able to do more work in most areas.

Elective admissions increased by 7 per cent between 2002/3 and 2005/6. Conversely the performance figures have worsened as the benefit of extra funding wore off with increasingly poor performance, eg only 77.1 % of patients treated within the 4 hour target in January beating the record worst performance set only a month beforehand.

The Essex Success Regime – a model for STPs ?

The Essex Success Regime was announced by Simon Stevens in June 2015 as the county along with areas in Devon and Cumbria had been singled out because of serial budgetary overspends. In Essex, after a year of behind the scenes deliberations, plan were announced to downgrade two of the three A&E departments. But these plans were revised after much public opposition.

The Regime has morphed into an STP. It appears to be one of the most advanced in terms of planning, being one of few now out to public consultation. The plans contain the now familiar themes of centralisation of inpatient services and supplementing the falling numbers of GPs with extended roles of other health workers such as receptionists becoming care navigators, although to date, few receptionists have volunteered themselves for this extra responsibility.

The plans also include more pharmacists and physiotherapists in surgeries along with newly created roles such as paramedics and physicians assistants. This approach could work, but how well will it work? My GP commented that all these staff will be paid from the practice budget, and when he recruits a GP he knows they can handle a wide range of issues and also that patients come with

a wide range of issues. He posed the question – how many of the new alternatives will it take to replace one GP and will the overall cost be more or less?

There are also major concerns about workforce planning and whether all the new professionals will be available when required. The STP is not answering these questions, they seem to be manipulated by remote control, by NHS England, and have not responded to the questions on how decisions are made.

Their attitude to public consultation has been to run well-prepared and managed meetings where facilitators concentrate on set topics, present an upbeat assessment of their plans and divert attention away from challenging questions. Some questions posed a year ago remain unanswered.

The attitude is that good things are happening as part of the *5 Year Forward View* (5YFV) and that all will turnout well. The published results of the vanguard sites from the 5YFV do not support this optimism. One of the main reasons for the STP is to shift care out of hospitals and into the community but NHS England's national performance dashboard for the Vanguard programme shows that, over the measurement period, there was a larger reduction in the rate of hospital bed days in non-vanguard areas than in the nine primary and acute care systems.

I still hear managers speaking, undaunted, of the need to reduce hospital attendances, particularly to A&E. To their credit the STP commissioned Healthwatch to survey people in A&E and invited the public to give opinions. The result was that 80% of A&E attenders were there on the advice of a health professional and most of the other 20% went there directly because they could not access urgent care elsewhere. The researchers commented that they perceived a lack of trust of the STP in part because of the stated purpose to save money.

The National Audit Office released its report on emergency admissions on the 2nd of March showing that It had not been possible to confirm the views of McKinsey that 40% of admissions are avoidable. The NAO conclusion: " A lot of effort is being made and progress can be seen in some areas, but the challenge of managing emergency admissions is far from being under control".

Other areas for concern include a belief in hi-tech solutions such as monitoring COPD patients through oximetry.Whilst studies have shown some success, a more detailed investigation showed that it was the presence of the nurse specialist conducting the study that improved care and not the readings from the instrument.

One more area where a seemingly good idea has had poor results is the GP extended hours initiative – where some GPs went to work at a 'hub', at weekends to give patients more opportunities to see them. The results were that patients calling at the weekend were told they had to wait for days as all the weekend appointments had already been booked by patients calling during the week.

The patients who saw GPs at the hub often went to see their own GP with the same problem – a duplication of effort – or went on to attend A&E. The practices whose partners took part in the hub project had a higher rate of their patients going to A&E. This suggests to me that the hub consultations were inadequate for the purpose. Possibly insufficient time or due to lack of continuity of care. It demonstrates the need to understand better why people go to their GP before rolling out more wasteful schemes.

Our position is that we must have adequate care established in the community before starting any initiatives to direct patients away from A&E departments.

Another area of concern is the local pathology service – part of an ongoing saga of abandoned plans and missed deadlines. A joint venture with a private supplier was set up because, we were told, our service was too expensive but it did what was needed. The new service has lost thousands of results and has become a laughing stock. The problems have been reported to the

trust board at two annual meetings and at a public board meeting. The response has been denial and eventually the news broke that the gynae cytology service had a false negative result of around 2% and that thousands of smears would need to be re-tested.

This was reported by the *Daily Mail* and BBC along with a comment that women who were concerned should see their GP. One local GP responded 'And why see me when the mistake was not mine? – Why not get an answer from the lab?' Yet another example of the public service having to make amends for errors in the private (or partly private) sector.

And the Next Steps?

Simon Stevens has published plans – the *5 Year Forward View Next Steps* shows a clear resolve to push STPs forward and this direct quote threatens any resistance. This reminds me of the plans to set up Independent Sector Treatment Centres earlier this century: a top-down initiative with each NHS region being instructed to set them up. It became clear that these were not good value for money and after the more pragmatic local doctors and managers reported the strength of opposition the plans were scaled down.

It may be that Mr Stevens has studied that programme as he now says:

> **"In the unlikely event that it is apparent to NHS England and NHS Improvement that an individual organisation is standing in the way of needed local change and failing to meet their duties of collaboration we will – on the recommendation of the STP as appropriate – take action to unblock progress, using the full range of interventions at our disposal. Where this has not already occurred, re/appoint an STP."**

They also state "ACSs will be an 'evolved' version of an STP that is working as a locally integrated health system". And that this will take years to

implement; they continue:

> **"In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services."**

This is the crucial point – why set up such an organisation and devise contracts?

Contracts are for lawyers resulting in wasted time while they argue over minutiae (good examples from the PFI experience). Health and social care professionals understand the patients' needs and will provide what they can. They will be guided by the organisations that set standards, the Colleges NICE etc, and we have run our services on these principles without taking out contracts. Parts of the service do require them, eg laboratories will have contracts with their equipment suppliers, but experience shows they are no guarantee of a high quality service.

I expect the local lab is working in accordance with its contract. If we must have contracts in a modern NHS then they must ensure patients receive the care and treatment they need and not make fear of the ACS – that ***Accountants Cut Services*** – a reality.

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The View From The Chair

Humpty Dumpty declared, "When I use a word, it means just what I choose it to mean – neither more nor less."

I was reminded of Humpty Dumpty when I tried to get to grips with a document proposing an accountable care system in my home town (or is it an integrated care system; or another creature entirely?). It was devoid of definitions or evidence and much of it could mean just what one chooses it to mean. When the description of the operational policy of the new organisation begins, "Implementation of a common vision for change that will guide the way we will operate, shape our values and behaviours and inform integrated decision making that remains engaged with wider conversations across West Yorkshire" you know that it is just words for words' sake. It is not meant to be understood and yet this kind of language characterises the output from NHS England, its colonies and dominions.

My involvement in one of the Judicial Reviews into Accountable Care Organisations (ACOs) has forced me to read much more of this kind of document than is good for me, I am certain.

The publication of a draft Accountable Care Organisation (ACO) Contract by NHS England in August 2017, and the promise from the Secretary of State that he would be laying regulations before Parliament to facilitate the use of this contract from Spring 2018, provoked an outcry from many groups, including DFNHS and Keep Our NHS Public (KONP). It became clear that the intention was for multi-billion pound contracts, lasting 10-15 years, to be set up with new non- statutory bodies, without parliamentary scrutiny and before any public consultation of the underlying policy.

These actions made it necessary to launch two actions seeking judicial review. One by the campaigning group 999 Call for the NHS questions the lawfulness of a capitation-based funding system, and has been scheduled for a hearing on April 24th.

I am a claimant in the other case, as part of the group JR4NHS, led by Professor Stephen Hawking and including Allyson Pollock, Sue Richards and Graham Winyard. We are seeking the court's opinion on the lawfulness of ACOs taking on commissioning roles that are, by law, restricted to Clinical Commissioning Groups and NHS England, and which cannot be delegated to other bodies, and we are also challenging the transparency of the process by which they are being introduced.

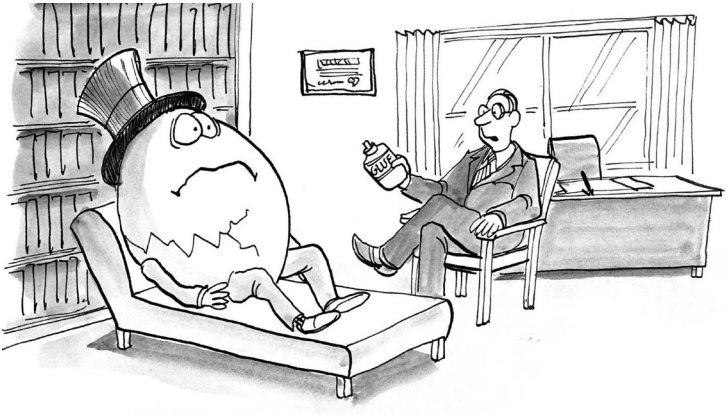
DFNHS as an association and many individual members have been extraordinarily generous in contributing to the raising of an incredible £280,000 towards the legal costs of the case. KONP has been phenomenally helpful in publicising the action and supporting it in other ways, as have Health Campaigns Together and other organisations and individuals. Together we have brought an awareness of ACOs to many more people and caused them to question the policy. The case has been reported by the main-stream media with a greater or lesser level of detail and this has been enough to cause some significant changes to the implementation of the plans. It remains to be seen whether these are temporary changes or something more substantial.

We had been seeking the court's opinion on the legality of using the ACO contract before public consultation, but in January, Jeremy Hunt relented and promised a national public consultation on ACOs, before any use of the contract. This meant that the plans for the first wave of ACOs to take effect from April 2018 would have to be deferred. As a result, we were able to drop that particular ground from our case.

At the end of January, the court granted us the Judicial Review that we were seeking, indicating that the case had sufficient merit to deserve a

full hearing. A second U-turn followed as Jeremy Hunt agreed not to lay the regulations that would permit the use of the ACO contract before parliament until after the consultation has concluded.

The estimated legal costs of the case were spiralling way beyond expected levels and making it difficult to estimate the level of funding required to see the case to a conclusion, despite the generosity of our supporters. We were therefore back in court in February to seek the security of a cap on the legal costs that could be claimed by either side: this was granted, and removed the last barrier to the Judicial Review taking place. The hearing has been scheduled for 23rd and 24th May.



"Visualize yourself not falling off the wall."

The lawfulness of the ACO contract is a question for the court and will be determined one way or another in May. The question of whether ACOs are an appropriate way to tackle the enormous challenges facing the NHS is for the people and the politicians of England to decide and is not a matter for the court.

These questions are being considered by the Health Select Committee of the House of Commons during the next couple of months. DFNHS and many other organisations and individuals have presented written evidence to the Inquiry and I have given oral evidence to the Committee. The written evidence is summarised on pages 10-13.

The promised public consultation is yet to be scheduled, but it would seem sensible to wait until the court has decided whether the proposal is lawful, before beginning a costly consultation exercise. This gives us a little time to raise public awareness of the extent of the changes that are being proposed, their potential risks, and to help people understand the way in which the NHS that they have been used to, could change beyond recognition. If, like me, you believe that these policies will have grave and lasting consequences, we have an obligation to convince our political representatives in local authorities and in parliament, to reject a commercial model of care services and to return to the public service model that was born in times of much greater austerity than we currently endure.

If our representatives are unable to imagine another future for the NHS, they need to look no further than the NHS Bill for a vision of a better and more optimistic destiny (www.nhsbillnow.org).

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Evidence for Consideration by the
What DFNS

Doctors for the NHS was one of the organisations presenting evidence to the Health Select Committee Inquiry in February. This is what they were told.

The Health Select Committee of the House of Commons began an inquiry into Sustainability and Transformation Partnerships (STPs) and their evolution into Accountable Care Systems (ACSs), before the General Election of 2017. They announced resumption of the inquiry last November and made a call for evidence, to which Doctors for the NHS responded (1).

In the meantime, NHS England announced that it would be issuing the first tranche of contracts for Accountable Care Organisations (ACOs) in spring 2018, so the inquiry was broadened to include ACOs (2).

Doctors for the NHS was invited to submit further evidence specifically on the question of ACOs (1). Ever light on their feet, NHS England have now decided that they will be encouraging Integrated Care Systems (ICSs) and the title of the inquiry, at the moment, is the "Integrated care: organisations, partnerships and systems Inquiry."

Doctors for the NHS contend that the proposed new care models are an inadequate response to the profound challenges facing the NHS and social care in England and that ACOs, in particular, carry serious risks, that have not been acknowledged, of a fundamental change to an important element of the social fabric or our country.

We do not oppose the ultimate goal of integrating health and social care, if done in the right way. People have been working towards the integration of care for years, before NHS England came on the scene, particularly through District Health Authorities. However, the key findings in the report into integration from the National Audit Office last year (3) found no strong evidence that integration would either improve the quality of care, or yield sustainable financial savings or reduced hospital activity.

What challenges do we face?

The problems confronting the NHS and social care have been well rehearsed in these pages. They include:

- The failure of levels of funding to keep up with the growth in overall population.
- The prolonged inadequacy of capital funding to permit maintenance of buildings, replace essential equipment in a timely fashion and allow development of the service in response to changing demands.
- The failure of forward planning for the provision of an appropriately trained workforce.
- The failure to appreciate that many in the workforce feel undervalued and demoralised by not being given access to the resources they feel are necessary to do a good professional job, contributing to problems with staff retention.
- The continuing reduction in the hospital bed base, despite a growing population, leading to enormous inefficiencies in the delivery of care.
- The totally inadequate investment in training and employing professionally qualified staff,

e Health Select Committee Inquiry: S Told Them

such as District Nurses, Health Visitors, School Nurses and others, to build up the capacity for primary and community health services and social services to provide the volume and quality of care that is needed for increasing numbers of seriously ill people in their own homes, in advance of the running down of capacity in the hospital sector.

- The hollowing out of the in-house skills, at a regional level within the NHS, that were concerned with the planning and management of a fairly complex service, to replace them with a dependence on out-sourced management consultants and other services at great expense and lacking insight into the public service ethos.
- The failure to introduce enforceable measures to restore mental health services to anything like an adequate level, rather than repeated platitudes about 'parity of esteem'.
- The continuing decline in NHS dentistry, due to inflation-busting escalation of charges, a disastrous contract imposition (2006) and the incompetence of Capita in supporting the service, among other factors.
- The gross constraints on local authority funding that have resulted in denial of support for very many vulnerable people and which are contributing to problems with the flow of patients through the care system that have been such a subject of concern. The very real possibility of the financial failure of one or more of the major care home companies fills many local authorities with dread, in view of their statutory obligations.

Will integrated care solve these problems?

DFNHS finds it very difficult to understand how bringing together an underfunded and overstretched health system, with an underfunded and overstretched social care system, under one organisation will of itself resolve these problems.

These system changes, of themselves, will not result in a single additional intensive care bed or district nurse.

It is as if the government and NHS England are saying, "Never mind all this; what the NHS and social care really need is Accountable Care Organisations"; another massive reorganisation, with the addition of a whole new administrative tier and changes to the contracts of a large part of the work-force, to help them through the upheaval and improve their morale. "Oh, and we won't give it a firm statutory basis: we will let it evolve naturally and see where we get to." "And, by the way, we want it to be done by yesterday. And no; of course you can't have any money to do it properly."

Many of the plans purport to address the factors that contribute to ill-health, but they seem to concentrate narrowly on the direct causes of ill-health, such as physical inactivity, poor nutrition, excessive alcohol and drug consumption, while paying scant regard to the social determinants of health, which have such a strong correlation with many of these behaviours, and which have been repeatedly and clearly expressed in the *Marmot Review* (4) in 2010 and the *Black Report* in 1980. People who feel that they have less control of their own lives through inequality of opportunities, working environment and economic insecurity

are at much greater risk of suicide, mental illness, perinatal mortality and premature death. This is not a problem just for those at the bottom of the pile; we are all somewhere on that gradient of increased risk.

The plans lay the "blame" at the door of the individual for indulging in unhealthy behaviour, while ignoring the broader influences that make such behaviour more likely to occur. Reinforcing the idea of "You brought it on yourself" opens the door to restriction of access to treatment: we are already seeing the denial of joint replacement surgery to obese patients and smokers, but personal behaviour contributes to very many illnesses and injuries, so the opportunity for exclusion is considerable.

What could possibly go wrong?

Many members of DFNHS have considerable experience in the design and development of clinical services. An essential part of the process is to draw up a risk register, acknowledging the potential adverse effects of the changes we are proposing, so we can take action to mitigate those risks. So far, there has been an unwillingness among the proponents of integrated care to admit that any risks might exist.

If everything is so hunky-dory, why does the USA, where Accountable Care was invented, have such an expensive health system with such appalling health outcomes? Why has the government of Valencia revoked the contract to Ribera Salud, amidst police investigation of allegations of corruption and fraud, large numbers of possible excess deaths and mass strikes of health workers, when that accountable care organisation was trying to roll out its model to Madrid?

Dissolution of the barriers between health and social care has been the stated intention of ACOs, but there has been no explanation of exactly how this would be achieved. Healthcare, at the moment, is universally available to the population, is fairly comprehensive and is free at the point of delivery, being funded almost entirely through general taxation. Social care, by contrast, is available to a shrinking proportion of the population, is largely funded by the individual, with means-testing and co-payments forming an important feature. If the boundaries are dissolved, does that mean that social care will also be universally available and funded through general taxation? We do not believe that to be the government's intention.

The definition of what is classified as healthcare and what is classified as social care is important when you consider whether to charge for care delivered by the new model of "generic" health and social care workers; the use of intermediate care beds, including "Care B 'n' B"; rehabilitation services and possible "hotel charges" incurred during hospital in-patient treatment. It appears that such decisions will be left to each ACO to decide. The possibility of patients receiving a bill at the end of their treatment for the 'social' element of a medical treatment has not been discussed openly with the public and has not been ruled out.

If the intention is the closer alignment of health and social care, why are we looking across the Atlantic? Why don't we just look across the Scottish border and assess the lessons that can be learned from a system that has been in existence for 15 years?

The government has made it clear that the model of ownership for each ACO is to be decided by that ACO. It may well be a Special Purpose Vehicle; a form of holding company, with a number of partners, which could all be public bodies, or all be private bodies, or a mixture. ACOs as currently planned would be non-statutory bodies, governed by contract law. They would not be compelled to respond to Freedom of Information requests, and it may well not be easy to challenge their decisions by judicial review, even if their constituent partners comprise public bodies. It has been said that an ACOs would "make most decisions about how to allocate resources and design care for its local population", so the lack of transparency afforded by 'commercial sensitivity' and the inability to challenge

the decisions of an ACO could have serious consequences.

The proposals for risk-reward sharing agreements for the partners of an ACO introduce, for the first time, the possibility of considerations of profit entering into the design and planning of health services. The ACO would have incentives to maximise its profit, which would then be distributed amongst its partners. It has been suggested that this arrangement would encourage public health measures to improve the health of the population it serves, so that the demands for care would reduce. But a more certain way of producing a profit would be to restrict the range of conditions treated and of treatments available, by applying more stringent eligibility criteria. This is what is usually termed 'demand management' and features in most STPs.

Another way of achieving a profit quickly would be to reduce the terms and conditions of the staff that work in the ACO. This was a major source of discontent in the Ribera Salud model, when attempts were made to roll it out to other parts of Spain. When retention of skilled staff is already such a problem in the NHS, this is a risk that should demand close inspection before allowing it in 'new models of care'.

It has been suggested that there would be little incentive for private companies to take on an ACO contract either by themselves or as a partner, because it would be difficult to make a profit from providing clinical services. That may be true just now, but property companies could be partners in an ACO and might be very interested in gaining access to the real estate of the ACO. The intellectual property accrued by the NHS and the public bodies within it could be extremely valuable, as could access to patient data. Financial companies could also be partners, to their benefit. There are many possible ways of making money out of public services behind the front-line.

What do we ask from this Inquiry?

Doctors for the NHS believes that these are legitimate concerns about ACOs that deserve to be either acknowledged and addressed, or clearly demonstrated to be unfounded. We trust the Health Select Committee will perform that role.

We also trust that the national public consultation on ACOs that has been promised by the Secretary of State will be in accordance with the Gunning Principles (5).

If this profound reorganisation of care services in England is to be attempted, our strong preference would be that the normal procedures involved in major changes to an important public service be followed:

a. Consultation by means of a White Paper.
b. Drafting of a bill informed by that consultation.
c. Scrutiny of the bill by parliament.
d. Enactment, subject to the will of parliament.

This would give a clarity and a firm basis to the proposed change that has been lacking in the process thus far.

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CEO Duty of Care to Patients: A Legal Perspective

The now fragmented and no longer "national" health service

As consequence of the removal of the NHS from democratic control by the Health and Social Care Act 2012 (which came into effect in April 2013), instead of one "national" health service, there now exists 271* separate providers of health services.

Each of the "independent" 271 health providers can make their own decisions as to how they actually provide the health services for which they are responsible.

The above are "independent", not only from the government, the Department of Health, NHS England (and its seemingly ever increasing subsidiaries (NHS Improvement, NHS Monitor etc) but also from each other.

Each one of the above can make their own decisions on how health services are provided, regardless on any "guidance" "advice" and or "recommendation" made by any of the above.

The same applies to their ability to ignore recommendations made by the Care Quality Commission.

There therefore now exists a nationwide variance in how health services are actually provided, which is far worse than the often criticised "post code" lottery that existed prior to the removal of the NHS from democratic control by the Health and Social Care Act 2012.

The above being of particular concern not only in relation to the initial diagnosis and treatment of patients, with serious illnesses including not only how long they have to wait for initial diagnosis and treatment to be provided but also to their aftercare.

The above being particularly detrimental to the well-being of patients such as stroke patients, whose outcomes depend not only on quick diagnosis and initial treatment but also after care.

The overriding "duty of care"

All of the 271* independent providers of health care mentioned above are under the control of 271 highly paid "Chief Executives" who owe an "overriding" (see below) "duty of care" not only to all the patients in their care but also to all their employees – particularly those at the front line of service provision.

The principle of "duty of care" is the requirement to avoid acts or omissions, which could be reasonably foreseen to be the source of harm either to patients or to employees.

In simple terms, this means that Chief Executives must (a) anticipate risks of harm being caused to both patients and employees, and (b) take care to prevent them.

Chief Executives in all the 271 "independent and free from democratic control" NHS trusts are paid very high salaries (far in excess of those paid to the Prime Minister) and unfortunately continue to be paid these high salaries even when they have been shown (by the Care Quality Commission) to have presided over appalling failures in patient care but have not suffered any penalty whatsoever either under:

(a) employment law (failure to abide by the implied or express conditions in their contracts of employment to exercise due diligence) for what amounts to gross management failures and/or,

(b) criminal law, for what also amounts to gross management failures including a proven failure

to comply with the overriding duty of care they owe to all their patients (and indeed to all their employees including doctors and nurses).

The lack of effective action, following the "avoidable/preventable deaths" identified as such by Robert Francis QC included the refusal of the government /Jeremy Hunt to take on board the most important recommendation made by Robert Francis namely that the government itself set minimum staffing level for nurses (and by implication at least, doctors) that all Chief Executives of all trusts should employ in all "front line" areas, including wards, and A&E.

Jeremy Hunt quite illogically, given the findings of fact included in the Francis Report, stated to the Health Select Committee, that the decision on "safe" staffing levels "should be left to individual Chief Executives" to determine!

The overriding "duty of care" owed to all patients

The "duty of care" owed to all patients or service user by Chief Executives, exists from the moment they are accepted for treatment or a task is accepted and they begin to receive services.

This may be, for example, on admission to a ward, acceptance onto a caseload or once registered at an accident and emergency department or accepted onto a waiting list for treatment.

Every Chief Executive has a "duty of care" to all patients or service users, even though that Chief Executive is not directly responsible for their care.

The duty requires that all that is reasonable must be done to secure the best outcome possible.

In simple language the duty of care requires every Chief Executive to ensure that there are (a) sufficient front line staff "on duty" at each operational level and (b) that there is sufficient bed capacity throughout service to meet demand.

A failure to comply with the above "overriding" duty of care which results in a "preventable/ avoidable" death, is *prima facie* evidence of the commission by the Chief Executive of the trust involved of the crime of manslaughter.

It is an unfortunate reality that the vast majority of the harm being caused to patients throughout the NHS are (a) as a direct result of a shortage of "front line" staff and/or (b) a shortage of beds leading to the reality of patients dying in corridors and in ambulances while waiting for admission to A&E or while waiting for admission to hospital in the first place.

The above not only resulting in preventable/ avoidable deaths, but also patients going blind and suffering other life changing effects of delayed admission to hospital.

The above are all *prima facie* evidence of a failure of the "Chief Executive" of the trust involved, to comply with the overriding "duty of care" that Chief Executive owed to all the patients involved.

If death or serious injury results from a breach of that overriding duty of care and a criminal prosecution results, a perceived or even proven "shortage of funds" is not a legitimate defence to a criminal charge of, for example, negligent manslaughter.

The relevance of a death being identified as being "preventable/ avoidable"

By very definition, a death that has been identified as "preventable/avoidable" means that the person who has an overriding duty of care to this individual (ultimately the most senior "manager" – the Chief

Executive – in that organisation) has failed to comply with that "duty of care".

Despite thousands of such preventable/avoidable deaths having been identified since 2013 not one investigation, let alone an actual prosecution, has taken place, even though sufficient evidence exists (in the findings of fact in the published reports of the Care Quality Commission and in the findings of fact in the Robert Francis report) to enable such a prosecution to be taken.

A proper and impartial enforcement of the criminal law in respect of the above serves two distinct purposes, namely (a) to punish the offender, and more importantly in the context of patient safety, (b) to serve as a deterrent to others.

The resultant improvement to "patient outcomes"

Although obviously unsettling for the Chief Executive involved, one result of the above would be the resultant focus on Jeremy Hunt and Theresa May for "not providing sufficient funds" to enable "safe numbers of front line staff to be employed" and "beds to be provided" in the first place.

The above named could not refer to the "NHS budget" as an excuse, as the court will be aware that, in law, there is no limit whatsoever to the money the government could allocate to the NHS each year out of the total tax income received.

The portion of the above that the government chooses to allocate to the NHS each year is purely a political decision.

It would only require one individual in charge of one of the trusts where a preventable/avoidable death has been identified as having occurred, not as a result of medical negligence but because of a failure of a Chief Executive to ensure that, either:

(i) there were sufficient suitably qualified staff at the front line of service delivery or

(ii) there was sufficient bed space available to avoid, for example, patients dying on trolleys in corridors or in ambulances while waiting to be admitted to A&E or

(iii) that patients did not die as a result of the length of time that patient was allowed to wait on "waiting lists" before being admitted for treatment.

The displayed failure to enforce the law relating to breaches of the duty of care by chief executives

Evidence is available to show that there appears to be a nationwide policy of all CEOs throughout the now fragmented NHS, including in the ambulance service, not to enforce the criminal law relating to breaches of the overriding duty of care owed by all Chief Executives to their "patients".

The significance of the above so far as patient care is concerned, is that it would only require one of the above to be prosecuted, for it to immediately result in significant improvements in patient care throughout the now fragmented NHS, far quicker that any of the measures being put forward by NHS England (and its ever growing offshoots) the DOH, Theresa May and Jeremy Hunt combined.

Solicitors in private practice are of course quite happy with the above as it generates literally millions of pounds in fees.

The reason Chief Executives are paid such high salaries is that, as the most senior "manager" in the organisation by whom they are employed, the "buck" stops with them and because they are personally responsible for ensuring:

(a) that sufficient staff are on duty, at all times at all "front line" service delivery areas,

(b) that there are sufficient beds at all times, to meet demand, and,

(c) that they have complied with all the obligations as the employer of all staff both under common law and statute,

In the context of the above, a failure to comply with any of the above requirements, is evidence

of the failure of the "Chief Executive" of the trust not only of :

(a) a failure to comply with the overriding duty of care every Chief Executive owes to every patient but also,

(b) evidence of a failure to comply with the duty of care every Chief Executives to all of their employees (see statement of ACAS to this effect).

The "duty of care" owed to all patients

As already mentioned, each of the 271 Chief Executives "in charge of any of the now (since 2013) "independent and free from democratic control" NHS trust owes a "duty of care" to every patient (as well as to every member of staff) .

A failure to comply with that "overriding" duty of care, which results in a "preventable/avoidable" death, is *prima facie* evidence of the commission by the Chief Executive of the Trust involved the crime of manslaughter.

The irrelevance of a claimed "shortage of funds"

If death or serious injury results from a breach of that duty of care and a criminal prosecution results, a perceived or proven "shortage of funds" is not a legitimate defence to a criminal charge of, for example, negligent manslaughter.

Although a successful such "plea in mitigation" may well result in a reduction in the punishment that would otherwise result.

However, a claimed "shortage of funds" may be difficult to justify/explain given the counter arguments that would inevitably be made, namely:

(a) The large increase in senior management positons that have been created in the 271 independent NHS trusts since 2013, and

(b) that all the Chief Executives and senior managers in the 271 "independent" NHS trusts have, since 2013, awarded themselves inflation busting salary increases on their already high salaries (in the majority of cases three times or more times the salary paid to the Prime Minister) while at the same time (in effect) reducing pay (given the rate of inflation) to the front line staff who are actually providing the health services the safe provision of which is the only reason the trust exists in the first place.

Removal of the NHS from democratic control by the Health And Social Care Act 2012

The running of the NHS was removed from democratic control by the Health and Social Care Act.

The above Act created 271 "independent and free from democratic control" NHS trusts*, over which neither the government, the Department of Health or NHS England have any direct control, other than determining how much of the overall NHS budget is allocated to each independent trusts each year.

Once that money is allocated, none of the above can control how that tax payers money is actually spent - they can now only "advise and/or recommend" but can do nothing effective if any of the Chief Executives of these independent organisations decide to ignore that advice and/or recommendation.

The only control they may have is to apply financial penalties (fines) which are then paid by the taxpayer and not by the Chief Executive who's identified management failures led to the fines being imposed in the first place.

These "fines" are therefore entirely ineffective as they do not:

(a) serve as a deterrent to the individual who is responsible for the overall management of the trust (the Chief Executive) and whose displayed management failures led to the fines being

imposed in the first place and who escapes any personal liability

(b) as the fine is paid by the taxpayer (the service user) and therefore only serves only to reduce the amount of money available to spend on patient care

(c) the same applies to any fines imposed following a prosecution by the Health and Safety Executive – again the resultant fine, imposed because of identified senior management failures, is not paid by the senior manager ultimately responsible (the Chief Executive of the trust involved) for the now proven "beyond a reasonable doubt" failure to comply with the overriding duty of care he or she owed to the patient who has died.

The above reality is why it is essential (in the context of patient care as well as a proper enforcement of the "Rule of Law") that "preventable/avoidable" deaths (identified as such by the Care Quality Commission) are investigated (and the individual responsible for that breach of the overriding duty of care prosecuted) in the same way as senior managers in all other organisations are, where a similar breach of a "duty of care" exists.

The effective irrelevance of prosecutions by the Health and Safety Executive to patient safety

There is currently, a gross waste of public money (NHS and taxpayer generally), as a result of prosecutions being brought by the Health and Safety Executive (itself funded by the taxpayer) against an NHS Trust (again, funded by the taxpayer) where identified "preventable/avoidable deaths" have occurred (usually as a result of issues relating to shortage of staff, effective staff training or other issues of "management" as identified, for example as in the Mid Staffs scandal).

The above taxpayer funded prosecution usually results in a massive fine being levied against the trust involved.

The above being paid, not by the Chief Executive responsible for the identified "management" failings, but out of the overall NHS budget.

Therefore these HSE prosecutions serve no useful purpose whatsoever in the context of patient safety. The massive cost to the taxpayer would be far better spent in employing more doctors and nurses in the first place. "Prevention is better than cure" in any event!

*Details of the 271 "independent" trusts that now exist:

135 Acute non-specialist trusts (including 84 foundation trusts)

17 Acute specialist trusts (including 16 foundation trusts)

54 Mental health trusts (including 42 foundation trusts)

12 Ambulance Trusts

35 Community providers (11 NHS trusts, 6 foundation trusts)

17 Social enterprises and 1 limited company

Kevin Riley
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CEO Duty of Care: NHS Staff

All Chief Executives in the now "independent and free from democratic control" NHS owe an overriding "duty of care" not only to every patient but also to all the staff they employ.

It is a well-known "management" reality that if you put staff under pressure , mistakes will inevitably occur – which, so far as the NHS is concerned, will inevitably result in either civil or criminal legal liabilities (or both – see below). The above primarily being the "fault", not of the staff involved, but of their "managers", for not providing sufficient operational staff in the first place.

Mistakes in patient care will inevitably occur unless managers employ sufficient staff to allow some "slack" in the system.

Staffing at a minimum operational level only is acceptable where the service provision does not involve the supply of health services.

The above effectively "unsafe" attitude to staffing at the front line of service delivery is, unfortunately, prevalent throughout the now fragmented NHS.

> "The effectively 'unsafe' attitude to staffing is, unfortunately, prevalent throughout the now fragmented NHS"

The above as a direct result of the creation (by the Health and Social Care Act 2012) of 271 "independent and free from democratic control" NHS trusts) each of which can make their own decisions on acceptable front line staffing levels regardless of any "guidance" in this respect issued by NHS England, the Department of Health or the government.

The above even after the damning conclusions in this respect, contained in the findings of fact in the Robert Francis Report issued after a lengthy investigation into the Mid Staffs NHS Foundation Trust which contained the identification of 1200 preventable/avoidable deaths – the primary cause of which, as identified by Robert Francis, being the fact that not enough nurses and doctors had been employed on the front line of service provision.. As a result of the above, Robert Francis QC recommended that the government itself set a minimum "safe" level of staffing to be employed at the front line of service delivery.

Jeremy Hunt, on behalf of the government, (quite illogically – given the findings of fact in the Francis Report) informed the Health Select Committee that the government was not prepared to accept this recommendation as the government considered that decisions on front line staffing levels was best left to individual trusts to determine.

The two major consequences of the above are,:

(a) that preventable/ avoidable deaths occur (as identified as such by the Care Quality Commission) continue to occur throughout the fragmented NHS, because of a proven failure of Chief Executives to employ sufficient front line staff or comply with the recommendations of the Care Quality Commission and,

(b) the fact that £56 BILLION of NHS (taxpayers) money that is having to be held "in reserve" by NHS England to cover claims for compensation against the NHS.

It is easy to imagine how many extra doctors and nurses and extra bed capacity could be employed

by the use of only a small proportion of that massive amount (which represents half the annual budget of the whole NHS).

The current situation only benefits the solicitors in private practice who receive massive amounts of taxpayers' money for pursuing claims against the NHS, many of which could have been avoided if sufficient front line staff had been employed and sufficient beds provided in the first place.

The duty of care owed by Chief Executives to all their employees

In addition to the duty of care owed to all their patients (which is enforceable by a proper application of the criminal law by the Director of Public Persecutions and the Police), Chief Executives and other senior managers in the now "independent and free from democratic control" 271 NHS trusts also owe a "duty of care" to all their employees.

Legally, Chief Executives in the NHS must abide by relevant health & safety and employment law, as well as the common law duty of care. Chief Executives and other senior managers have a duty of care to their employees, which means that they should take " all steps which are reasonably possible to ensure their health, safety and wellbeing" (according to ACAS).

This is particularly relevant in the context of staff such as doctors and nurses who are working on the front line of service delivery. ACAS also states::

(a) that "demonstrating concern for the physical and mental health of your workers shouldn't just be seen as a legal duty - there's a clear business case, too as it can be a key factor in building trust and reinforcing your commitment to your employees", and also

(b) it can help improve staff retention.

ACAS also states that "requirements under a Chief Executive's duty of care are wide-ranging and may manifest themselves in many different ways, such as:

- Clearly defining jobs and undertaking risk assessments.
- Ensuring a safe work environment.
- Providing adequate training and feedback on performance.
- Ensuring that staff do not work excessive hours.
- Providing areas for rest and relaxation.
- Protecting staff from bullying or harassment, either from colleagues or third parties or "management".
- Protecting staff from discrimination.
- Providing communication channels for employees to raise concerns.
- Consulting employees on issues which concern them.

Kevin Riley
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NHS Governance: An Uncomfortable Lesson From History?

DFNHS member David Zigmond argues that the current ideals marketising our NHS have unsettling parallels with the flaws of the Bolshevik system

There is a time-honoured principle and skill involved in all medical practice: we must be vigilant to those times when our interventions are making people ill, or iller. Ignoring this in public policy can cause exponential damage.

Unlikely co-examples? The USSR 90 years ago and our contemporary NHS governance.

It is a hundred years since Russia's Bolshevik Revolution, so in western Europe its trail of vast sufferings and menaced privations can now easily be dismissed as historical relics: nightmarish follies from a world and era very different to our own. Yet we should be cautious, and remember a timeless adage: if we do not learn from history, we are bound to repeat it.

Some would find it hard to believe there can be any serious resemblance between the systems of Soviet anti-market communism of the twentieth century and compulsory marketisation forces by neoliberalism in the twenty-first. Here are two widely spaced accounts that paradoxically converge.

USSR late 1920s: grain for the people

Stalin, with his hallmark uncompromising resolve, was determined to industrialise and centralise his vast and now thralled empire. He saw this as essential to national survival: a Five Year Plan would corral and galvanise. This necessitated mass-migrations of rural populations to newly-planned, rapidly growing, factory-based cities. So this then meant that far fewer farm workers would have to produce a much larger crop-yield: greater efficiency. They would achieve this by being collectivised. Small land-owning farms would be merged, under state control, and work with otherwise unaffordable machinery (eg tractors). The state's requirements would be clearly prescribed: provision would be tightly managed.

The results were very different from this official plan: in fact the output declined massively and tragically. Understanding what, why and how this happened can be very instructive for us now.

Collectivisation's fatal flaw was its disregard of motivational or social psychology. The Plan did not

heed what gave poor small farmers' lives work-satisfaction, dignity, belonging and meaning: the very smallness of their tended lands and communities enabled a sense of autonomous pride, familiarity, identification and easy fraternalism. High levels of motivation and productive work emerged from these endogenously.

By contrast, the state-directed giant collectives coerced a very different modus operandi. Farmers were immediately displaced, disempowered, disinvested and thus alienated from their more natural communities and their satisfactions of self-management.

Hitherto, despite their lack of modern technology, those small farmers had been efficiently productive: they were reliably self-sufficient and could sell much surplus yield. So this naturally evolved atomised market of small players worked well: notably there were no famines.

Collectivisation quickly led to a resistant disintegration: many farmers initially objected, but they remained unheard so they then refused to cooperate. Stalin, never one to be openly defied, ordered immediate deportations, beatings, destruction of homesteads and mass shootings. Farmers' doomed resistance became suicidal. The now unprecedently meagre crops were immediately confiscated from the farmers, who then starved. Vast famine areas hosted the death of millions. Deliberate human destruction on this scale had no precedent: its 'peacetime' context only added to the perverse catastrophe.

Accurate knowledge of these terrifying reforms remained confined and obscured for six decades: until the USSR's collapse. The little description that leaked out was quickly attributed by the Soviet authorities to misreporting, conspiratorial untruth or to the peasant workers themselves: their self-serving and devious greed had returned them merely retributive and ruinous justice, and the henceforth despised collective term: *Kulaks*.

Stalin's USSR continued a similar trajectory for another 25 years, frightened into obedience by two more Five Year Plans. Did they succeed? On one level, yes. Stalin's cravenly industrialised monster-state was able to match, and then defeat, Nazism – a kind of kindred behemoth. Churchill commented, with ambivalent admiration, that Stalin's regime entered a Russia equipped with wooden ploughs and left it with nuclear weapons – a miserably totalitarian superpower.

And the price the citizens paid for the 'progress'? Millions lost their lives. Millions more – if that can be imagined – lost a life of health, trust, sanity, community and family. Witness accounts are now dwindling with extreme old age. Longer-shadowed memories live on less directly, less consciously and epigenetically.

England late 2010s: healthcare for the people

For 30 years our mother-of-democracies has pedalled, advised and advertised a very different ideology: neoliberalism – the market will best decide what people want and need; it should be made compulsory. Competitive free markets serving customer choice and investment will then not only rouse entrepreneurial spirit and intelligence, but financially incentivise the workers. Yes, some people can become much richer than others, but that contentious objection is countered by efficiency enhancements and – most important – marketisation acts in the greater interest of the population by avoiding the kind of deadening and dangerous centralising control so starkly enacted by Stalin's market-hating communism.

Geared to our best technology and industrialisation this social-economic approach – neoliberalism – can guide and define almost all our wants and needs, not just our consumer objects and experiences but also our welfare – how we care for one another…

That is the theory: that our welfare can thrive best when based on such market-based principles, especially when these are safeguarded by governmental quality assurance and inspection. This, in outline, has been the increasingly ratcheted plan for our welfare services vaunted by successive governments over the last three decades. This is

particularly true of our NHS.

The plan sounds all good, surely? So how has it worked out? Well, as with the Bolshevik Five Year Plan, the results depart far from the intent. Neither the practitioners, nor the public, nor the essential finances are behaving as they should. Mercifully our democratically-mannered government does not respond to these discrepancies with the violent, often homicidal, rhetoric of the Soviet communists. But elsewhere the mechanisms and events unleashed by our market-mandated and industrialising governance have some remarkable similarities.

How have neoliberalism and our many industrialised reforms damaged welfare services? It is here that we need to understand three devices that have propelled and steered our 'modernisation': marketisation, REMIC and gigantism. Each of these need some brief notes of definition and comment:

1 **Marketisation.** Intention: to deliver health services according to patient choice; to financially incentivise practitioners' performance and entrepreneurial innovation; to improve services by competitive commissioning.

Unintended consequences: 'cherry-picking' by providers for short-term commitments and profits – gaming the system; replacement of colleagueial cooperation by commercial competition; enormous bureaucratic and legal costs to commissioning and contracting – consequent losses of funds for practitioners, together with losses of trusting fraternalism and morale. Many of these problems are then accentuated by a fundamental market hazard: the tendency to ever-larger mergers and corporations whose eventual size and power becomes, in effect, a controlling monopoly. Perversely the 'market' then loses any possible beneficence and resembles more an irresistible totalitarian state. (Contrast this with the *kulaks'* small-scale, atomised commerce which worked well, and without the hazard of monopolistic power and centralisation.)

2. **REMIC (remote management, inspection and compliance).** Description and intention. This refers to all governmental devices that attempt to ensure safety, competence and probity in and between the increasingly marketised services. These 'watchdog' functions are pursued by centralised agencies which, largely by complex IT programs, issue practitioners with ever more detailed service requirements, and then methods of surveillance to ensure compliance.

Unintended consequences: Fostering of an increasingly procedural tick-box culture of submissive compliance. Emphasis more on short-term control rather than longer-term understanding. Loss of core skills, interest and engagements in favour of demonstrating institutional compliance. Consequent displacement of vocation by corporation. Growth of mistrust, blame and anxious insecurity; conversely, loss of fraternal colleagueial cooperation, trust and supportive networks. Intimidated and demoralised alienation of staff with inevitable morbidities and losses.

3. **Gigantism.** Description and intention: This is similar to manufacturing industries and retail: whenever they can they will 'scale up' to expedite centralised control, mass production, standardisation and economies of logistics, administration and resources. There has been an equivalent adoption of gigantism throughout the NHS.

Unintended consequences: The plan-driven, poorly judged closure of smaller units – hospitals and GP surgeries, for example – usually leads to similar difficulties produced by REMIC (see 2, above). Generally, personal understandings, trust and good personal bonds develop best in smaller units that offer stability and thus familiarity – this is true both in colleagueial interactions and in pastoral healthcare: the doctor-patient relationship. The converse is true of very large institutions: the personal is often sacrificed to the procedural. The hazards, too, are similar to REMIC: anxious demoralisation in a lonely crowd.

So these three bulwarks of neoliberal markets

and modernisations in our NHS are all there to service an ideology avowedly opposed to the erstwhile monolith of the market-destroying Soviet communism. Yet, paradoxically, both ideologies seem to share some of the same hazards.

How is this now working out?

At the time of writing, not at all well.

The flaws of marketisation, REMIC and gigantism are becoming ever-more evident and the promises more elusive. There has been much recent media coverage of the restive, destabilising discontent among nurses, junior doctors and GPs. Hundreds of stories have emerged of their mounting and unheeded frustrations. They frequently describe a procedurally ratcheting compliance culture which demands unrealistic targets served by diminishing resources. All this is overseen by a frequently punitive and micromanaging surveillance regime that is experienced as unmovably remote, or itself paralysed by some uber-management. No wonder such healthcarers express exhausted demoralisation.

What else could we expect from people attempting very difficult work – both technically and humanly – who feel so little personal recognition, understanding or supportive colleagueiality yet are very aware of omnipresent devices for their surveillance, control or elimination?

Yet 30 years ago these same professions were very different: they had keen recruitment, high morale and peaceful work relationships and satisfaction. This was true despite working-hours often being longer and pay no better. It seems clear that our difficulties lie largely in the nature of our now-institutionalised relationships and how this has changed the nature of the work.

Metaphorically, our good-enough (and often much better) family has been sacrificed to an alienating and sternly mistrustful factory.

Several months ago the junior doctors again challenged the government about the lack of funding for the NHS, to provide the kind of service the government is now demanding, by decree. The government countered this with a slew of doubtful statistics 'proving' an increase of real funding over demand. But the Health Secretary did not stop there: he attacked. No, he said, the apparent shortage of funds is a mendacious distraction: the real problem is the doctors' inefficiency, their resistance to progress, their self-serving and sly greed. The *kulaks*, alone, are to blame for any famine!

What received little mention in this insurrection-interruptus was how the modern reforms themselves have become a major source of financial inviability. The cumulative effect often gains momentum by successive reforms often amplifying the flaws of previous reforms. For example, the administrative and legal complexity of merely running the NHS market is enormous, yet rarely with any clear or enduring benefit. REMIC then

multiplies both the economic and human costs. The result? A procedurally dense culture that erodes professional trust, cooperation, morale and autonomous intelligence and will ultimately lose far more of value than it can create. Unless we are very careful gigantism will merely scale up such follies.

And here we find another historical equivalent to the legacy of Bolshevism: for much of the USSR's habitual poverty was inescapable from the enormous expense of the state's ubiquitous surveillance and repression. Defending the existence and reputation of unviable government ideologies usually becomes economically and humanly crippling. That is true, whether it is Bolshevism or unmitigated neoliberalism.

Meanwhile what do we see?

With unprecedented frequency healthcarers are burning out, dropping out, getting out or being taken out – often the equivalents of professional suicide or execution. Those that remain suffer a variety of dysthymias (mostly stoically), or self-palliate with drugs and alcohol (when stoicism runs out). Such breakdowns are, increasingly, the harbingers of that most tragic response to the unendurable: personal suicide.

And, of course, such a milieu must affect the quality of any care we may give. If we cannot find our own headspace or heartspace, what can we find for others? How many patients now are likely to see a family doctor who will offer a relationship of growing personal understanding? How many know the name of the hospital specialist they last saw? These last two questions may seem trivial, but the answers signify much else: the increasing and unviable human-relationship famine in our health service.

Even if the technology holds up, and even if we can find the right money (for a while), this famine will continue … until we realise and understand that many of our tribulations are due to our specious, often draconian, reforms. The cure has become the illness: a remarkable achievement for a health service.

So the harsher the regime – the more uncompromising and regulated we make our behaviour and surveillance – the worse it will get.

Hopefully we can learn faster than the Bolsheviks.

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Interested? Many articles exploring similar themes are available via David Zigmond's home page on www.marco-learningsystems.com

Bawa-Garba: Campaigners Urged to Write to GMC Chief Exec

Members of Health Campaigns Together and Keep Our NHS Public have been urged to write to the Chief Executive of the General Medical Council following its recent response to Dr Hadiza Bawa-Garba's conviction for negligence manslaughter.

Keith Venables, Secretary of HCT:

> **"This major point of debate and dispute is around the conviction of Dr Bawa-Garba of negligence manslaughter for the tragic death of a young boy in the context of horrendous staff shortages, equipment failures, inappropriate staffing, poor communication etc – ie in the immediate context of a failing system at that time when she was working as an NHS employee and trainee."**

Campainers are being urged to complete and forward an online letter to the GMC CEO, Charles Massey.

The text of the letter

"Dear Mr Massey,

We are writing to you to express our overwhelming concern regarding the General Medical Council's (GMC) response to the recent Department of Health consultation on professional regulation, in addition to the GMC's handling of the Bawa-Garba case.

Currently, all doctors have the right to a fair trial and professional tribunal when things go wrong, to explore the context in which errors occur and determine a doctor's fitness to practise. It has come to our attention that the GMC has proposed to deny doctors this right, and to extend the powers granted to it by parliament in the Medical Act 1983 by seeking to unilaterally erase doctors from the register. Although we understand you are seeking to do this in the case where a doctor has been convicted of a "serious criminal offence" we are dismayed to learn that this includes gross negligence manslaughter.

The Bawa-Garba case saw a paediatric trainee with a previously unblemished record be convicted of gross negligence manslaughter despite the systemic failures that likely contributed to the tragic death of Jack Adcock. The case, and the subsequent action of the GMC, has caused widespread concern internationally, throughout the medical profession and amongst patient safety experts. The implications are such that the case has prompted Jeremy Hunt, Secretary of State, to announce an urgent review into the application of gross negligence manslaughter in healthcare.

The Medical Practitioners Tribunal Service (MPTS) did not recommend that Dr Bawa-Garba be erased from the register, citing numerous mitigating factors and taking into account the systemic failures of the case. The GMC inexplicably chose to appeal this in court. In a recent letter to Sarah Wollaston, you referred to your own "clear and published guidance" detailing the process of appealing MPT verdicts, but a recent Freedom of Information request revealed that you, as Chief Executive, appear to have made this decision to appeal to the court to have Bawa-Garba erased from the register unilaterally.

It has now come to light that upon reviewing the case, the GMC's regulator, the Professional Standards Agency (PSA), has criticised this action finding that the argument that the GMC had "no choice" but to appeal the MPTS decision was "incorrect" and "without merit" given established

case law. Indeed, the PSA found that the MPTS "considered all relevant principles and applied the case law appropriately".

We are therefore shocked that you, knowing full well the results of this review, which was conducted last year but disappointingly not published by the GMC, stated in recent weeks "the tribunal had essentially placed itself above the law in reaching that decision". Your statements appear at best, misguided, and at worst, disingenuous. This is more concerning given that your own regulator, the PSA, had found that "the Panel was not seeking to go behind the conviction or minimizing it". You further stated "it is a very difficult argument to win that doctors should somehow be above the law or the law operate differently for doctors". We, as doctors, do not believe we are above the law and are affronted that you would suggest so. The PSA in their review, however, state "it appears the GMC is seeking to create a line of case law which establishes a distinction in how the courts approach appeals by a regulator".

Given the above we are firmly opposed to any such extension of powers being granted to the GMC and would like to remind you of the following:

• In Cohen v GMC (2008) the High Court established that the GMC must focus on doctors' current and future fitness to practise

• A number of court rulings have further clarified that the role of the GMC is to determine whether the doctor poses a future risk, and not to discipline them for past conduct

• The GMC states that a secondary function of a fitness to practise hearing is "providing an opportunity to rehabilitate and remediate doctors whose fitness to practise is impaired"

• Further, the GMC states that any action taken must be proportionate and to act otherwise would be "inappropriate and unlawful"

• The GMC also states that any sanction issued to a doctor must be the minimum sanction necessary to protect patients

• In reviewing the action taken by the GMC in the Bawa-Garba case, the Professional Standards Agency pointed out to you that the Supreme Court (a higher court than that to which the GMC appealed for Dr Bawa-Garba's erasure) in 2016 had previously established that professional tribunals were better placed than courts to determine professional competence

We call on you to do the following:

• Withdraw your response to the Government's consultation with immediate effect

• Abandon attempts to push for automatic and unilateral erasure and commit to the right of all doctors being allowed a fair hearing

• Acknowledge that inclusion of Gross Negligence Manslaughter as a "serious crime" for which automatic erasure would be pursued is highly inappropriate in the context of widespread concern regarding how this is currently applied, and pending a review of the use of Gross NegligenBawa-Garbace Manslaughter in the United Kingdom

• Clarify the process by which the GMC chooses to appeal certain outcomes of the MPTS and how this applied in the case of Dr Bawa-Garba

• Clarify what processes are in place to ensure institutional bias against Black and Minority Ethnic doctors does not play a part when considering which MPTS decisions to appeal

We look forward to your timely response.

Yours sincerely"

What can you do?

- Complete the online letter, either on the Keep Our NHS Public website (www.keepournhspublic.com/news/gmc-must-not-deny-doctors-a-fair-hearing) or ours (www.doctorsforthenhs.org.uk/category/news).
- Tell colleagues about why this represents a grave and present threat to the profession and the NHS, triggered by years of under-resourcing and staff shortages.

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