DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

"We make health possible for one another"
Archbishop Sentamu– page 25

Fighting charges for migrants – Page 4
The BMJ Essay winner – Page 28
AGM and Conference 2019 – Page 13

NOVEMBER 2019

CONTENTS

Editorial –
Make the Difference **3**
Andrea Franks

The Price of Compassion **6**
Jonathan Folb

Not on My Watch: A Local Success Story **9**
Alan Taman

The BMA and PCNs **11**
Anna Athow

AGM and Conference 2019 – 13-27

AGM Reports – **14**

Speaker presentations – **18-24**
James Skinner, report by Morris Bernadt
Louise Irvine
Kate Pickett, report by Alan Taman

The Paul Noone Memorial Lecture:
"Whatever you did for one of the least of these" – **25**
The Most Reverend Dr John Sentamu, Archbishop of York

The BMJ Essay Competition –
Our Profession in Today's NHS **28**
Sarah Marie Farrell

Executive Committee 2019-20 **32**

Managing Editor – Alan Taman
healthjournos@gmail.com
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Make The Difference

And so in the end he did nothing at all
But basked in the sunshine wrapped up in a shawl
I think it disgraceful the way he behaved
Doing nothing but basking until he was saved
– AA Milne: The Old Sailor

The sentiments of AA Milne's old sailor (who his grandfather knew) will have considerable resonance. That overwhelmed feeling, not knowing where to start and feeling powerless anyway, is all too familiar. Maybe this sailor was in fact just a little lazy as well as being confident that shipmates from the mighty British Navy would, in any event, rescue him, which, of course, they did.

Mercifully there are those who have regarded the overwhelmed feeling as a challenge to be overcome and not an excuse for basking until salvation arrives, because it probably won't .

When Greta Thunberg, then 15, sat on her own outside the Swedish Parliament one Friday afternoon in August 2018 holding a home-made 'school strike for the climate' placard, she had been alarmed about climate breakdown for several years and felt she just had to do something. She had no idea whether anyone would even notice her. The next day a few others joined her. By July 2019, over a million students in 125 countries were participating and she had spoken at Davos, at the House of Commons and other parliaments and at numerous rallies in various countries including North America. She has won several awards and was even nominated by Norway in May 2019 for a Nobel prize. 23% of Swedes have now not flown in the last year and Sweden has some new words, *flygskam* meaning the shame of flying; *tagskryt*, the smugness of going by train; and *smygflyga,* flying secretly and hoping people will not find out. A 2019 YouGov poll in the UK showed that the environment is now our top public concern, but Greta's best accolade was an OPEC statement in early July which said that she and other young climate activists were "the greatest threat to the fossil fuel industry". In Greta's words, "no-one is too small to make a difference".

> "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has"
> *– Margaret Meade*

The climate emergency has huge implications for worldwide public health, and for every one of us. The hottest day on record in the UK caused travel chaos in a week which brought us Boris Johnson, a PM who even most of his colleagues thought unsuitable and who was elected only by a tiny group of elderly Conservative members. Mr Trump has described Boris Johnson as "the UK's Trump" and has welcomed him to early trade talks but we must sincerely hope Trump's assessment could be wrong, though evidence so far is far from encouraging. According to Steve Bannon (speaking on CNN Politics in May 2019) "the core of Trump's platform is the deconstruction of the administrative state", while Donald Trump himself said on television that "of course the NHS will be on the table in trade deals". He may later have retracted this, but it seems absolutely certain that the NHS and so much else, such as food standards and environmental issues, will be more threatened than ever before.

A recent 'Dispatches' programme revealed secret talks with US pharmaceutical manufacturers, which could mean huge price rises for NHS drugs. An election is imminent, and we must not forget John Major's comment in 2016 that "the NHS is about as safe with them (Boris Johnson, Michael Gove and Iain Duncan Smith) as a pet hamster would be with a hungry python."

As well as many years of austerity (our own version of deconstruction, with cuts in all public services), growing inequality is damaging society in the UK in many ways, and is contributing enormously to mental as well as physical health problems and to children's development and education as well as their happiness. In this we are unfortunately following the US rather than, for instance the Scandinavian countries. Under this Government any hope of a more equal society seems unlikely as Boris Johnson has praised inequality as "being essential for the spirit of envy and keeping up with the Joneses that is, like greed, a valuable spur to economic activity".

It is so easy to be despairing, to be overwhelmed by events and to feel powerless to influence them, but we can often do far more than we realise.

Climate breakdown is a monumental threat to the entire planet and all its inhabitants and must be confronted, but there are so many more local issues to address at the same time, most of these related to Government policies. The unkind imposition of 'migrant charges', which most of those affected are completely unable to pay, was intended to exaggerate the issue of 'health tourism' which looms large in the tabloid press but in reality costs at the very most 0.3% of the NHS budget. In this issue DFNHS member Jon Folb writes about his campaign at the Royal Liverpool Hospital and the widespread support he has had from hospital staff including over 200 of his consultant colleagues.

In 2005, the NHS Consultants Association (now Doctors for the NHS) and the NHS Support Federation started (and has always partially funded) the national Keep Our NHS Public campaign which has active groups throughout the country, linked to numerous other health campaign groups locally, and nationally part of the umbrella organisation Health Campaigns Together. Many DFNHS members are active in local groups, and their clinical knowledge is extremely helpful. Local concerns do remain very important and will often raise general awareness of what is going on nationally.

> "Bad men need nothing more to compass their ends, than that good men should look on and do nothing."
> *– John Stuart Mill, quoting Edmund Burke*

What can we actually do to draw attention to a local issue? Mary Whitby and colleagues from Merseyside KONP saw a 'Mychoice' advertisement from Warrington Hospital, offering patients the chance to pay (at roughly twice the tariff cost) to have surgical procedures which the CCG had decided to stop commissioning – part of a gradual erosion of NHS provision intended to encourage private health insurance. They achieved considerable publicity and the advertisement has now been withdrawn, but campaigners remain vigilant.

Anna Athow and the other DFNHS members on BMA council are playing a vital part in influencing BMA decisions and understanding and explaining the effects of national NHS policies. Several such as Allyson Pollock, Jacky Davies and David Wrigley have written well-researched books which explain exactly how the erosion and ultimate destruction of the NHS has been planned and what is now happening. DFNHS continues to receive queries from the national press and we have been quoted several times by national media over the year. More often, journalists working on a health story

have contacted Alan Taman (our Communications Manager) for advice off the record, reflecting our credibility as a reliable source.

Most Britons, whatever their party loyalties, feel that NHS services should be publicly provided, not run for profit and all the evidence shows this is right. Privatisation is, however, continuing under cover of media concentration on Brexit, while opposition to the regional structures which are essentially becoming US style Accountable Care Organisations (and in which UnitedHealth subsidiary Optum is already heavily involved) is made far more difficult by the deliberately confusing terminology, such as calling these 'integrated care'.

The 2019 Reith Lectures given by Jonathan Sumption were about the interrelationship between government and the law. At the end he focused on the inequities of the two party system and the erosion of democracy and democratic process, this erosion going on almost invisibly whilst on the surface nothing appears to change. His final sentence was that 'if it happens, it will be our own fault'.

There is much to challenge.

Bernie Sanders, opposing Trump and his philosophy in the US said, "…anyone who thinks it is time to despair and give up, this is not that moment".

Greta has shown the way and this is no time for basking till rescue arrives for there will be no rescue. Groups of thoughtful, committed citizens can change the world and need to alter its course rather than let whatever dark forces at present at work continue to wreak their havoc.

Andrea Franks
Editor
roger.franks@btinternet.com

An Appeal

Peter Fisher, our President, is appealing to any members who know there are particular problems where colleagues may be more interested to hear about *Doctors for the NHS* to get in touch directly. Any suggestions on this would be welcome, because for many years Peter has contacted consultants in a given area with the aim of recruiting more members, and targetted mailings tend to be more effective.

If you know of any trusts, practices or individuals in your area who would be interested to hear from Peter, please let him know:

nhsca@pop3.poptel.org.uk

Dr Peter Fisher
Hill House
Great Bourton
Nr Banbury
Oxon OX17 1QH

The Price of Compassion

Staff at the Royal Liverpool Univeristy Hospital have taken a stand against healthcare charges for migrants: something Bevan expressly cautioned against for the NHS

The NHS is founded on the principle that healthcare should be free at the point of use to all who need it.

Bevan was clear on the question of whether the NHS should provide free treatment to overseas visitors: he thought it would be "unwise as well as mean" to withhold free treatment from visitors to Britain. He was wary of the bureaucracy and inconvenience that would be required to classify people – "for if the sheep are to be separated from the goats both must be classified", and considered this to be an issue on which "generosity and convenience march together". He rejected the argument that foreign visitors do not contribute to national revenues, and observed that the cost of treating visitors amounted to no more than a negligible fraction of the overall cost of the health service. In his view, critics had "tried to exploit the most disreputable emotions in this among many other attempts to discredit socialised medicine".

However there has long been provision made for charging patients not ordinarily resident in the UK. Currently, under the Immigration Act (2014), hospitals are obliged to identify patients without "indefinite leave to remain" in the United Kingdom and to charge them up to 150% of the usual cost of their care. In 2017 a further statutory duty was placed on hospitals to charge patients up-front if they were found to be ineligible for free care. NHS Trusts share personal data with the Home Office during the process of determining eligibility for free care, and are encouraged to report unpaid debt. This data can in turn be used by Home Office Immigration Enforcement teams.

A number of exemptions apply – for certain kinds of immigrants (like refugees and asylum seekers, survivors of torture or trafficking), for certain kinds of services (like treatment by GPs and in Accident and Emergency), and for certain conditions (principally transmissible infectious diseases). But the exemptions are confusing, for clinicians and hospital administrators and certainly for migrants, and it can be difficult for people to prove that they qualify for exemption. This has resulted in patients sometimes being inappropriately charged, and in a climate of fear about presenting for health care. Furthermore, while treatment is free for many infectious diseases, patients are likely to be unaware of their diagnosis if they are deterred from seeking healthcare, and would still risk being charged for other comorbid conditions.

Doctors and other healthcare professionals in my hospital and many others around the country are concerned about the consequences of these regulations, and are campaigning for them to be repealed. Within the past few months the BMA, the Academy of Medical Royal Colleges, and the Royal College of Midwives have all called for the Regulations to be suspended or scrapped.

Raising awareness amongst doctors

I first became properly aware of the issue when I attended a meeting in November 2018, organised by Keep Our NHS Public Merseyside, and the Save Liverpool Women's Hospital campaign, and supported by Docs Not Cops, These Walls Must Fall, Refugee Women Connect, Asylum Link

Merseyside, South Yorkshire Migration and Asylum Action Group. The speakers included Rayah Feldman, who spoke in detail about the Maternity Action report, "What Price Safe Motherhood?". This report strikingly highlights the vulnerability of women subjected to charges for maternity care, the complexity of their circumstances and of immigration status, and the psychological and financial stress that resulted from being issued with bills they were unable to pay. It is part of a growing body of evidence of the harm and distress caused to migrants by healthcare charges.

Clinical colleagues I spoke to afterwards generally had a limited awareness and understanding of the regulations. I decided to arrange a meeting to raise awareness of the issues, to give people an opportunity to express their views, and to try to gauge the appetite for challenging what is happening. Approximately 60 people attended a lively evening meeting in January – they included mostly doctors – of all grades and specialties - from the Royal Liverpool University Hospital, but also a small number of medical students, GPs, public health doctors, academics and non-clinical staff. Several people recounted personal experiences of patients being deterred from seeking treatment or pursued aggressively for payment. There was an overwhelming view amongst people at the meeting that the regulations are undermining people's trust in the health service and likely to be damaging to individual and public health, and that our Trust should be challenged to adopt a public position opposing them.

Three of us met with the Trust Chief Executive to outline our concerns. He was sympathetic but wanted evidence that our views were more widely shared amongst doctors within the organisation. A survey of opinion elicited responses from more than 200 doctors at the Royal Liverpool University Hospital, more than 90% of whom expressed serious concerns about what is happening, including 4 departments who wrote en masse calling for the Trust to make a public statement supporting the Colleges' position that the regulations should be suspended. The principle themes amongst the responses were:

- That the charges are unfair and inhumane, and that the people affected by them are often vulnerable and unable to pay, and that the health service has no place in the "hostile environment" for migrants.
- That the application of charges is likely to be discriminatory and might involve some form of racial profiling.
- That denying patients treatment because of their inability to pay is irreconcilable with what people see as their duty as doctors, and counter to the principles of the NHS as a free and universal service.
- That it might influence clinical decision-making and result in people being offered sub-standard care.
- That sharing patient's details with the Home Office undermines people's trust in the health service and in us as doctors.
- That there is likely to be a deterrent effect on people seeking healthcare, resulting in later clinical presentations and consequently risks to individual and public health.
- That the effects of late clinical presentation undermine the economic arguments for charging.

A minority of respondents expressed the views that:

- The NHS is a national not an international health service, and that we can't afford to treat the whole world.
- That healthcare is expensive, not free – the NHS is desperately short of resources, and this is an important source of much-needed income which can be invested in trying to improve a struggling system.
- That one would expect to have to pay for medical treatment received while travelling abroad, so it's not unreasonable for the same to apply to visitors to the UK.

Developing a campaign

Having ascertained the strength of feeling amongst clinical colleagues in the hospital, we agreed on a mission statement and set up a web page, hosted by MedAct, to raise awareness and allow healthcare workers in other organisations in Liverpool to register their support (https://www.medact.org/2019/actions/sign-ons/a-letter-from-royal-liverpool-healthcare-workers-to-the-trust-board/). We held a Grand Round and invited outside speakers involved with asylum seekers and refugees, and spoke at Consultants' meetings in other hospitals. A referral was made to the Trust's Clinical Ethics Committee, who agreed that legitimate ethical concerns had been raised and referred the matter upwards within the governance structures of the organisation. The campaign is also being formally and forcefully supported by the joint Staff Side representing all unionised staff at the hospital, by PC24 –an organisation providing out of hours GP services in the city, and which also runs a practice for asylum seekers, by the Merseyside BMA Junior Doctors' Committee, and by the MP for the hospital's constituency.

What we are asking of the Trust is to make a public statement acknowledging the concerns of many of its staff, and supporting the calls by the Royal Colleges and the BMA for the regulations to be suspended or scrapped. Our hope is that this would encourage other hospitals to do the same. But we have also asked the Trust to examine the way that charging is implemented in the hospital, and to change its systems in such a way as to be as lenient and humane as possible while still complying with the law.

The Trust has been open to discussion about the practicalities of implementation, but reluctant so far to adopt a public position. We have been invited to re-write the policy for charging overseas visitors, and have now done so despite some concerns about becoming complicit in something with which we disagree. At a meeting in October this approach was endorsed by the campaign, with clear red lines agreed before the discussions that will now follow with the Trust. We have also drafted a public statement for the Trust and intend that this will be included in the policy as a preface.

Conclusion

What has been truly inspiring for me has been realising how passionately committed doctors are to the principles underpinning the NHS, of fairness and equality. Our campaign has drawn on and benefited greatly from the efforts of campaigners at Medact and Docs Not Cops, and from campaigns at other hospitals such as Barts. I would specifically like to thank Greg Dropkin (KONP, Liverpool) and James Skinner (Medact) for their support and guidance, and the very many inspirational doctors of Liverpool.

Further reading

Aneurin Bevan (1952) *In Place of Fear*

Maternity Action (2018) What price safe motherhood? Charging for NHS Maternity Care in England and its impact on migrant women. Maternity Action UK (https://tinyurl.com/ych66mq2)

Doctors of the World (2017) Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances. Doctors of the World UK (https://tinyurl.com/ydh5yapq)

Medact (2019) Patients Not Passports: challenging healthcare charging in the NHS. Medact, London UK (see also www.PatientsNotPassports.co.uk)

Jonathan Folb
Consultant Microbiologist,
Royal Liverpool University Hospital
Jonathan.Folb@nhs.net

Not on My Watch

How a local health campaign worked through the local media

Warrington Hospital began advertising for people to pay for elective surgical procedures that the local CCG had deemed no longer 'warranted' funding, under the beguiling slogan 'My Choice' (which will probably sound familiar to members as yet another re-marketing of the 'Patient Choice' illusion).

Mary Whitby and her colleagues from Merseyside Keep Our NHS Public decided to campaign against the ad by mounting a 'counter-campaign' via the local media:

"We first learned about the MyChoice advert on around 14th June. I liaised with Felicity and we agreed we would write to our MPs, all the MPs in the vicinity of the hospital trust, the trust CEO and I also wrote to *The Liverpool Echo*. Felicity and other local campaigners such as Greg and Alex, shared the letter to *The Echo* with campaigners and campaign groups and it spread quite quickly as far as the south coast and over to the east coast and up to North Yorkshire.

"We received emails of support and ideas for questions about MyChoice from campaigners around the country. They were also writing articles and blogs about MyChoice. We also decided to share the information via social media and tagged in the hospital trust. *The Echo* didn't print my letter as far as I know but it spread as if they had. *The Echo* did print an article though and approached the trust for a comment.

"They put out a press release as did my MP Rosie Cooper who also called for the resignation of Mel Pickup the trust CEO. What was particularly worrying was that she was also the CEO of the Merseyside & Cheshire STP.

The *Daily Mirror* picked up on the story and wrote an article. Campaigners in Warrington organised protests outside the hospital. Within a couple of days we drafted a leaflet highlighting the costs and asking people to contact the MPs in the area and the trust. We called an emergency meeting at which we learned that the trust had paused the scheme! We agreed that we would continue with protests locally in Warrington, outside The Royal, at Ormskrik night market and at all the upcoming Liverpool festivals and events where SLWH campaigners were already going to protest.

"We drew up a paper petition against NHS charges and also initated a parliamentary petition. (Unfortunately the petitions department at the Houses of Parliament took several weeks to consider the petition then recently rejected it as they claimed it was similar to an existing petition.) We heard that Simon Stevens made a comment in a parliamentary committee that the marketing of MyChoice by the trust had been misguided. We gave out around 5000 leaflets over that initial 3-4 week period. We then learned that Mel Pickup was standing down as CEO at the trust and at the STP!

"We consider that our campaign was a success as we managed to speak to thousands of people and raise awareness and we secured hundreds if not thousands of signatures on our paper petitions."

Why Did This Work?

Mary's account shows how a local group can and often does make a difference, by engaging with the local media. Each example will be different, but the power of the local press, even though

Well done, Mary!

greatly diminished, should not be under-estimated.. Especially where, as here, the campaigners took the trouble to mount their campaign using several communications 'channels' at once. Social media, printed leaflets and petitions were all used here to great effect, because the action was coordinated.

An encouraging sign from all this is that it did not cost a fortune. Printed leaflets are very cheap to print, and a professional looking appearance is fairly easy to achieve even with universal programs such as Word.

Mary's account illustrates several keys to success in governing principles which the media – social and traditional – operate by. These are called 'news values' and it's clear that this campaign abided by several: local importance, health itself, the NHS charging for what should be free (controversy), the fact that the media will use the media itself (national media will often pick up a local story, if the news values translate to the national stage). Standing back from an issue to consider which principles may be at play, and which might be brought to play with relative ease, is a timeless process used by effective campaigners and huge PR firms alike.

Unlike the latter, local campaigns do not have vast budgets to mount expensive advertising campaigns, but as this example shows, determined local action can counter professional advertising and marketing campaigns which are in fact undermining the principles of the NHS.

It is easy to be swayed by the vast 'information wars' currently being waged by political parties in the pre-election frenzy, into believing small local campaigns can never compete. But Mary's words show this is not so. Local people, acting locally, have immense reserves of local knowledge and often support to draw from, which all the PR glitz in the world will find hard to counter. So it should. Because if the NHS is to survive and the heartless march of commercialisation is to be halted, local battles are where the war will be won.

Alan Taman
healthjournos@gmail.com

The BMA and PCNs

The Annual Representative Meeting of the ARM spanned two whole days and two half days, Monday to Thursday 23 to 27 June. Ample time one would think to assess the biggest privatisation reforms to the NHS since the Health and Social Care Act 2012.

NHS England's "The NHS Long Term Plan" 7.1.19, (LTPlan) and the associated national GP contract change for England - " Investment and Evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan," 31.1.19. (GP Framework), embody a colossal top-down reorganisation to impose American style accountable care systems and providers in England.

But these highly sophisticated documents were not given due allocation of time or appropriate position on the agenda for representatives to fully debate and understand the huge significance of their contents.

The GP Framework outlines the new general practice structures necessary for implementing the LTPlan. New Primary Care Networks (PCNs) consisting initially of large groups of GP practices, and later other medical providers public and private, trigger the establishment of a few large integrated care systems (ICSs) in England.

The following quotations refer to the process.

"By April 2021, ICSs will cover the whole country, growing out of the current network of Sustainability and Transformation Partnerships (STPs)" (p 1.51 P 29 LTPlan.)

PCN representatives sit on the ICS partnership boards (p 1.52)

"ICSs will be central to the delivery of the Long Term Plan and by April 2021 we want ICSs covering all of the country." p 1.75 P110 LTPlan)

"In the NHS Long Term Plan PCNs become an essential building block of every integrated Care System...(p 4.2 P 4T GP Framework).

"PCNs will be a fundamental building block of every ICS, essential for achieving ICS goals."(p 6.1 P 40 GP Framework)

ICSs are the fore- runners of Integrated Care Providers, and were formerly called Accountable Care Systems and Accountable Care Organisations. ("Next Steps of the Five Year Forward View" 2017 Ps 35-37).

Doctors for the NHS supported a judicial review against NHSE imposing Accountable Care Organisations in England in 2018.

At the ARM, the Chairman of Council devoted one sentence to the LTPlan and did not reveal its key aim of setting up ICSs all over England by 2021. He avoided mention of the GP Framework. Its discussion was relegated to a 15 minute slot on Wednesday afternoon.

Dr Vautrey Chairman of the GP's committee (GPC) in his report in that session, praised the GP Framework and lauded the new PCNs as the way to save general practice, but said nothing about their role as 'the building blocks of ICSs' to cover the country by 2021.

The motion in the GP section came from London region, and called for the immediate withdrawal of the GP framework and a vote by all GP BMA members (which has been denied them.)

The mover said that the GP Framework demands "GP practices and their patients join new model Primary Care Networks PCNs). These are different because practices must sign up to a Network Contract DES (laid over their core GP contract), commanding a £1.8bn Network funding stream and tying GPs to "new specifications, like working in multidisciplinary teams of non–doctors working to network protocols." The GPs must also sign a new legal "integration" 'Network Agreement' – to enable other providers, such as Virgin – run community care, hospitals, social care, mental health, dentists, etc to become members."

"PCNs are the building blocks of ICSs' and work under ICS/STP direction, as the PCN clinical directors sit on the boards. They must obey LTPlan

objectives; to cut spending and commit to 'Shared Savings Schemes', whereby the less hospital care your patients receive, the more money the ICSs make."

"These structures have never been seen in the NHS before and totally change the GP-patient relationship.

By what right can GPC agree, that patient lists, currently owned by GP practices, are taken over and co-owned by ICSs all over England? This is a heist of 55 million NHS registered patients!

The "evolution, through multi-year contract change and ' integration' with all medical services… fattens ICSs up into ICPs which could be run by private companies for profit.

GPs working for ICPs would lose their independent GMS contracts and any vestige of clinical autonomy.

But this contract reform will totally transform the lives of all doctors, all NHS staff and all patients, by helping NHSE to get ICSs launched nationally on the US model and speeding up privatization."

The GPC spokesperson against this motion, made the following points:

1. 'Shared savings schemes' are not about making profits, but preventing unnecessary patient attendances at hospital.
2. ICSs do not lead to ICPs.
3. General practice is 'drowning' from lack of funds
4. The Framework is to "save" general practice -" a float to stop GPs drowning"
5. It was necessary for GPC to lead and make the decision to accept the Framework, before a possible change of government! (1)

Dr Vautrey commented as follows: "The BMA and GPC has fought against and lobbied against the ICP contract since its conception.

"Practices would give up their GMS contract to be part of an ICP contract and then those fears that some highlight would come true.'"

"The PCN arrangements [are based on] the GMS contract – we retain our independence and our ability to advocate for our patients as independent contractors. This contract protects us from the ICP contract. We need it, we need it to work and practices around the country are already starting to make it work."(1)

The leaders of NHS England, however see this differently. Their joint committees met the morning, after the vote at ARM to oppose the GP framework was lost. They happily agreed a report on the 27.6.19 stating that " PCNs are mission critical for ICSs." (2)

The fact is that by pushing GP practices to join PCNs, the BMA are collaborating with NHSE in continuous GP contract reform for 5 years, to set up ICSs – thus facilitating the growth of ICPs covering 1-3 million people as huge autonomous private profit-making bodies running health and social care in England on NHS long term NHS contracts (i.e. as huge public- private partnerships.)

I agree with the verdict of the third speaker in support of the motion, Dr Gill, SE London GP. He said: "Make a note of this date 26th June 2019, the day when our medical leaders not only betrayed the profession but betrayed our patients."

The good news is that on the Monday morning, representatives showed their support for keeping the NHS as a publicly funded and provided service prioritising patient need, and in particular voted for a resolution to oppose the NHS Long Term Plan.

References

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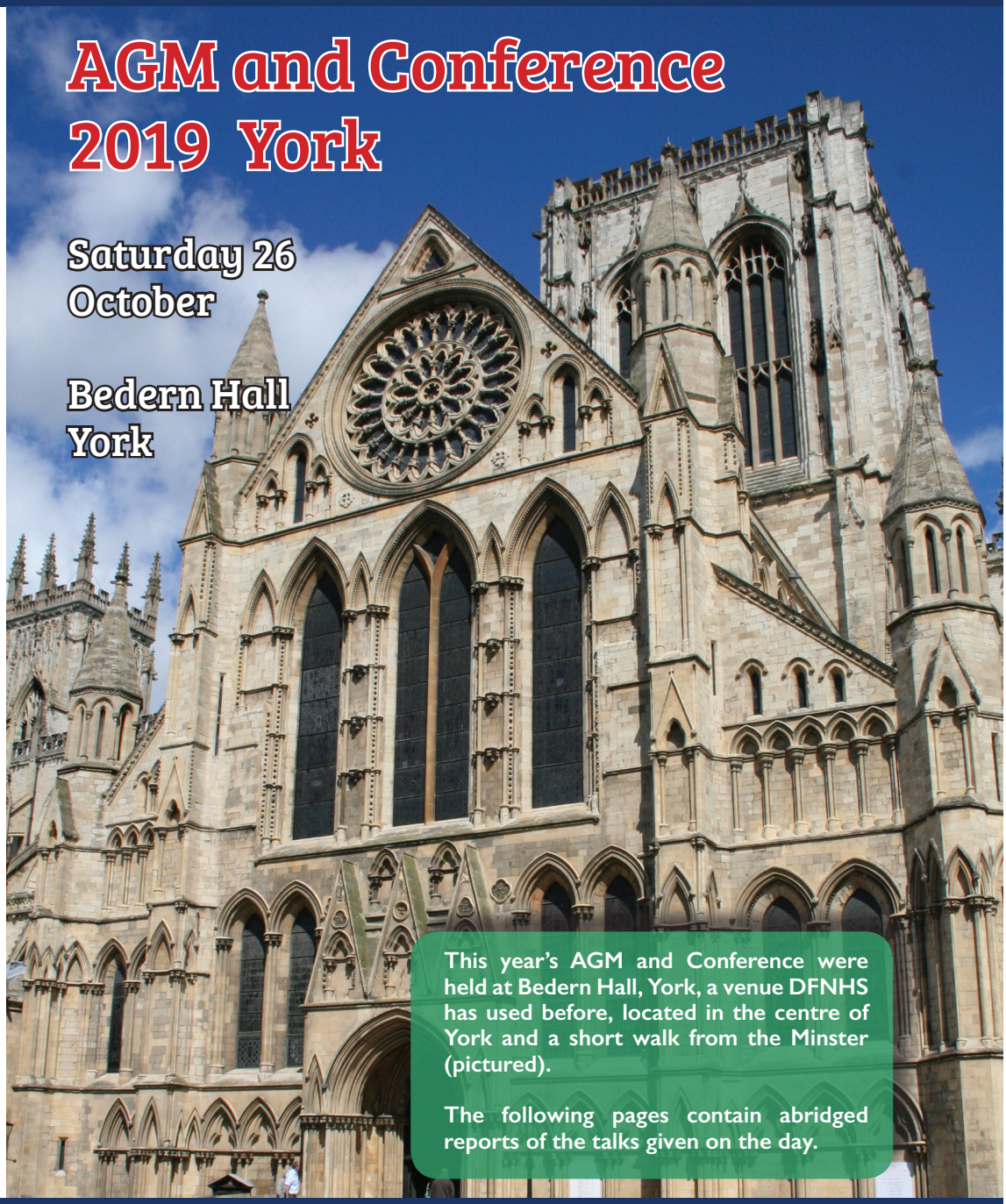
2 NHS England (2019) Paper "Implementing the Long Term Plan in primary and community services." para 42. Available at:
https://www.england.nhs.uk/wp-content/uploads/2019/06/6-Primary-Care.pdf

Anna Athow
annaathow@btinternet.com

AGM and Conference 2019 York

Saturday 26 October

Bedern Hall York



This year's AGM and Conference were held at Bedern Hall, York, a venue DFNHS has used before, located in the centre of York and a short walk from the Minster (pictured).

The following pages contain abridged reports of the talks given on the day.

AGM Reports

Treasurer's Report: Peter Trewby, Treasurer

Summary

Total Amount in feeder account in October = £17,050 + £3500 in our current account. Overall there has been an improvement since 2018 despite a drop in members, which as previously discussed could free up money for other projects. The graphs show fluctuations in our deposit balance over the past 12 months and over the past seven years. The recent increase is due to receiving the subscription from a new life member.

Donations

Since the AGM we have donated £1000 to the NHS Federation, £50 affiliation to Health Campaigns Together,

£2000 to Keep Our NHS Public (KONP), and £2000 to the Centre for Health and Public Interest (CHPI). We received £500 from Scottish Health Campaigns who campaigned for the preservation of small hospitals but is now being wound up. We offered money to "Docs Not Cops" but received a grateful reply saying they will let us know if and when money is needed. With our current bank balance, we have the potential to give £8000 to causes of our choosing.

Subscriptions

10 new members this year. 22 resignations this year (including 4 deaths). 642 active paying members including 34 GPs and 14 trainees.

Essay Prize

This attracted 50 excellent entries including

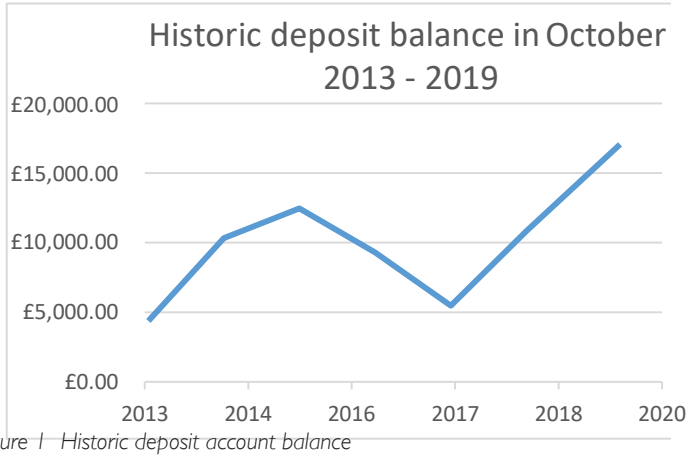


Figure 1 Historic deposit account balance

nference 2019

2 from overseas. Roger Franks and I selected a shortlist which we shared with the BMJ. The agreed winner was Sarah Farrell (prize-money £500) and second Lucy O'Connor (£200). The BMJ will publish the winning entry and possibly one of the overseas entries. This year the essay prize only led to 2 new members, the title perhaps picking up doctors more interested in criticising rather than preserving the NHS. We need to choose next year's title.

Overall

Despite resignations, the finances are healthy. We can afford next year's essay prize and should consider any expenditure which might draw in more members and further our wider aims.

Communication Manager's Report: Alan Taman

The year has seen continued success with the quarterly newsletter, which remains well received. This now features interviews with key figures in related fields and will continue to be improved so as to keep members informed. It remains the only reliable method of reaching the whole membership on a regular basis, as roughly a third of our members have no e-mail address listed. This will probably change over time and will continue to be monitored. The production schedule was moved to allow earlier reporting of the AGM to all members: issues are now printed in late October or November (depending on the date of AGM), January, April and July.

The website continues to serve as a good way for members to join and blogs are added for significant events or press story responses.

Press enquiries continue to be made, most recently from the *Mail on Sunday* (Scotland), and press releases are sent out in response to major press stories about the NHS. All enquiries are responded to within deadline.

Our Facebook and Twitter streams continue to grow modestly but steadily. We have around 1900 followers currently.

These areas reflect the bulk of the communications role as it now stands, following a 50% reduction in funding to sustainable levels by mutual agreement over the past year.

The frequency of website blogs and social media posts has increased in the past year but ideally could be increased further, to at least weekly for the former and at least daily for the latter, to attract more attention. There is scope for more members representing DFNHS to populate the social media streams.

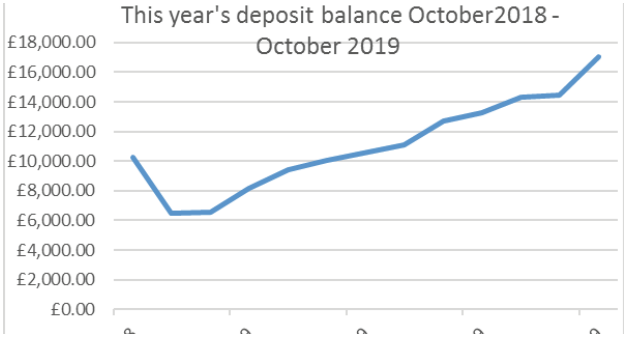


Figure 2 Deposit account balance

Chairman's Report: Colin Hutchinson, Chair

In a turbulent political year, the continuing struggles of the NHS have assumed a lesser priority, unless you happen to be working in the service or receiving (or not receiving) treatment. It has been harder to engage the attention of MPs, but we have continued to build links with other campaigning organisations and influence the debate.

Working collaboratively

I represent DFNHS on the Steering Group of KONP, attending most meetings, as have several other members of DFNHS. This enables the exchange of information and ideas from groups across England, confronting local changes, but following a centrally-directed script. A number of DFNHS members attended the excellent, recent Mental Health Crisis Summit, organised by KONP, focusing on this import ant and neglected aspect of the NHS. I would like to encourage as many members as possible to join their local KONP groups and bring their professional experience to those campaigns .

We are affiliated to Health Campaigns Together, which brings together trade unions and campaigners and produces a highly informative quarterly newspaper. Representatives of KONP and HCT seem to be having success in influencing Labour policy on restoring the NHS as a publicly provided service , as can be seen in the response of Jeremy Corbyn to the Queen's Speech and announcements at the Party Conference.

DFNHS affiliated to the Doctors Association of the UK (DAUK) in January 2019. We had been impressed by their dynamic organisation and engagement with doctors in training and the possibility of bringing together the ideals of those embarking on a clinical career, with the experience of seasoned campaigners, seemed attractive. We need to devote more effort into building these links.

DFNHS joined the Smoke Free Action Coalition in March 2019. This is designed to fulfil the aims of the All Part y Parliamentary Group on Sm oking and Health.

Docs Not Cops campaign against the hostile environment on the provision of universal healthcare. As a grass roots organisat ion, they do not accept affiliates, but James Skinner is speaking at our annual conference to tell us what they have been up to and we would encourage members t o join in an individual capacity.

The DFNHS Essay Prize 2019 (in conjunction with the BMJ)

The title of this year's essay, "Where have all the doctors gone - and why?" resulted in about 50 entries. Particular thanks goes to Peter Trewby, who took the lead in organising and judging the competition, together with Roger Franks. Congratulations to the winner, Sarah Farrell, but there were also interesting contributions from doctors in the Phillipines and Zimbabwe, which put a very different perspective upon this question – their doctors have gone to countries with relatively better pay and prospects, such as the UK!

There have been more younger members joining DFNHS since the essay prize was launched. This had been acknowledged as a priority for the Association and the intention is to make this a regular event, but we are realising the importance of the choice of subject in encouraging creative thinking.

Under the Knife

This feature-length documentary follows the evolution of the NHS from its inception to the present, showing that much of the current problems are a result of deliberate political strategy. It features interviews with many key players and contributions from a number of DFNHS members, myself included. It has not been taken up by any networks, but free screenings have taken place

across the country, funded by trade union branches and crowdfunding. These screenings have featured question and answer sessions led, in some cases, by DFNHS members.

Integrated Care Provider Contract Consultation

One outcome of the judicial review of the move to Accountable Care Organisations (aka Integrated Care Organisations) was that a public consultation took place into the Integrated Care Provider (ICP) Contract. I submitted evidence to that consultation, alongside the other claimants in that judicial review. It is impossible to say whether that evidence was considered. The ICP contract has been introduced, although none have yet been concluded. The role of the judicial review in delaying their implementation in the hope that the political focus might change and they might never come to pass might be considered some kind of victory?

Patient Safety Consultation

NHS England held a public consultation on "Developing a Patient Safety Strategy" over the New Year, to which DFNHS contributed, largely through the effort of Eric Watts, emphasising that the recommendations of" An Organisation with a Memory" (2000) had not been properly implemented, but that the circumstances under which mistakes occur need to be considered; that the lessons learned from previous adverse events need to be refreshed regularly at a departmental level; and that policy recommendations should be accompanied by risk assessments, so that there is, at least, a recognition that mitigating actions have been put in place to guard against the adverse impact of such policies.

The NHS Long Term Plan

This was published in January 2019. It set out sweeping changes in the organisation of primary and community care, with attendant risks and possible benefits. Potentially positive announcements were the acceptance that further reduction of hospital beds should not occur, unless there were clear evidence that they were surplus to requirements.

There were also signs that the calls of DFNHS to reduce the emphasis on specialist skills, at the expense of broad clinical skills, had eventually been recognised, with an inclusion of the idea that a significant training period within District General Hospitals might improve recruitment to DGHs.

Proposals for a system of credentialing could assist doctors to expand their range of skills, following appointment to substantive posts.

Legislative proposals to support the Plan have been included in the recent Queen's Speech. These seek to get around particular aspects of the Lansley Act, to facilitate the Integrated Care Provider Contract, with the reduction in public accountability and increased scope for commercialisation of large swathes of the NHS. These changes fall very short of revocation of the 2012 Act. They also do nothing to reduce the risk to the NHS in any future trade deals. These remain key campaigning points for our association.

Election of Executive Committee

All members of the current EC were invited to stand again. Brigid Hayden asked to stand down owing to other commitments.

Reports from Other Groups

Reports were received from Keep Our NHS Public and the NHS Support Federation.

Speaker Presentations

James Skinner

James is Access to Healthcare Campaigner at Medact and has had extensive experience of organising actions for Patients not Passports and Docs not Cops

Report by Morris Bernadt

Medact was formed in 1992 as a merger of two organisations: the *Medical Campaign Against Nuclear Weapons* and the *Medical Association for the Prevention of War.* After the merger Medact recognised the need to adopt a much broader global health agenda – one that would incorporate the health threats posed by unjust economic policies and their implementation together with, more recently, the profound threat of climate change. Medact works to mobilise, support and organise health professionals to be more effective agents for social change.

Patients not Passports and Docs not Cops

The NHS was designed to be a universal health service, free for all that need it. This is no longer the case. As part of its Hostile Environment immigration policies, the Government has been restricting access to care for some people. This drastic shift away from the founding principles of the NHS is having a devastating impact on patients who are unable to pay. The policy is changing the culture in our health service, making charging for treatment acceptable and opening the door to a system where access to care is dependent on ability to pay.

Charges apply to secondary care services whereas, with certain exceptions, GP and nurse consultations in primary care remain free. As the government puts it "The UK's healthcare system is a residence-based one, which means entitlement to free healthcare is based on living lawfully in the UK on a properly settled basis for the time being". Scotland and Wales have different regulations to England.

Currently immigrants without settled status have to pay 150% of the NHS tariff and this also applies to their children. Trusts have a statutory duty to charge. To establish the right to free treatment, two forms of ID are required which includes a passport, but 17% of the population have no passport. The burden falls on marginalised people. Since 2015 Trusts have had discretion to write off debt if the patient is clearly unable to pay e.g. the destitute, but Trusts can pass on debt to families or the patient's estate. How many Trusts are monitoring the impact of NHS Charging? None. In 2017 upfront charging replaced retrospective charging and there was an increase in chargeable services, some extending into the community. The person arrives in hospital and there are questions about residential status, then: please pay. A sick child might be denied treatment if the parents cannot afford it. Immigrants e.g. pregnant women might eschew necessary hospital contact for fear of data crossing to the Home Office. Avoiding necessary hospital contact increases the likelihood of emergency treatment at a later stage with increased cost. The government's own figures show that healthcare tourism accounts for only 0.3% of NHS funding.

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Action

At a nationwide level

- Stop charging for NHS care and repeal the 2015 and 2017 NHS Charging Regulations
- Stop sharing patient data with the Home Office and ensure clear separation between NHS Data and Immigration Enforcement
- Commission a full and independent inquiry into the impact of NHS charging on individual and public health, and provide compensation to the families and communities already impacted.
- Patients not Passports has an on-line toolkit dealing with campaign tactics
- https://patientsnotpassports.co.uk/

Locally

- workplace organising. Staff see the awful impact of government policies and can be advised on how to proceed
- build links to other local organisations e.g. KONP
- talk sense to the media
- organise activity outside of hospitals e.g. street stalls

The BMA and Academy of Royal Colleges have come out against charging and recommended that it should be scrapped. Silence from the GMC.

Louise Irvine
The crisis in general practice

Louise is a GP in Deptford and a member of DFNHS. She is Co-Chair of Health Campaigns Together; Chair of the Save Lewisham Hospital Campaign; and Secretary of Doctors in Unite (formerly the medical Practitioners Union)

I was lucky enough to train in General Practice in the 80s which was in many ways a golden age for the development of the philosophy and practice of general practice, with new ideas evolving, such as patient centred care; the primary health care team; and holistic care covering the biopyschosocial dimensions of a person's problem. The concept developed of the patient as expert and of the consultation as a meeting between experts; so did the idea that GPs had a vital role in prevention and management of long term conditions as well as the acute problems patients present to us. There was a growing understanding of the social and psychological dimensions of health and illness and the importance of the GP understanding the kinds of pressures our patients were facing within wider society. At that time the general hospital physician gradually started being phased out: more care was being transferred to general practice especially for long term conditions like diabetes, and the idea grew that general practitioners were specialist medical generalists, based in the community and not in hospitals.

The concept of the Primary Health Care Team developed, including District Nurses and Health Visitors – recognising that GPs can't and shouldn't do everything by themselves. The specialty of Practice Nursing has increased the ability to care

for much larger numbers of people with long-term conditions.

General Practice, with a growing confidence, a growing body of academic evidence showing the value of the model of British primary care, and a growing scope of practice, became an increasingly popular career choice for young doctors. It should have been in a good position to get the support needed to develop further, including more GPs, more time for consultations and more resources to develop the wider primary health care team.

That has not happened. Since 2010 it is estimated that General Practice has lost about a billion pounds a year. The workload has increased but the resources have not kept up. Since 2010 there has been a 30% increase in consultant numbers but the number of GPs has fallen.

England's NHS has lost nearly 600 full-time equivalent GPs over the past 12 months.

An analysis by the Nuffield Trust for the BBC shows the number of GPs per 100,000 people has fallen from nearly 65 in 2014 to 60 last year.

GPs are seeing twice as many patients a day compared with 30 years ago.

Consultations are often significantly more complex (1).

GPs are finding their workload stressful and exhausting and many are voting with their feet and either not joining general practice after training, or leaving early. Those that remain find themselves in even more difficult conditions and sometimes this is unbearable.

Almost 140 surgeries closed last year alone - more closures than in any previous year, and almost eight times the number seen in 2013,

It brings the total number of closed GP surgeries to 583 since 2013.

In conjunction with the Nuffield Trust and The King's Fund, the Health Foundation also found the overall NHS workforce shortfall could increase to 160,000 by 2023/24, which includes a shortfall of 7,000 GPs (2).

Last year, a survey published by The King's Fund found that only 37% of GP trainees planned to become partners – while just one in five planned to stay working in full-time clinical general practice a year after qualifying (3).

Patients are unable to get appointments to see a GP for weeks, and are even less likely to see a GP that they know and who knows them personally. Service provision is suffering. Immunisation rates have dropped and one reason is the lack of availability of nurse appointments. Surveys show that while people still value their GP they are getting angry and upset and losing confidence in General Practice.

Why does this matter?

British General Practice, based on the principles of personal, continuing, community-based care, has proved over many decades to be clinically effective, efficient and popular. There is strong evidence that continuity of care saves lives and protects patients from unnecessary and harmful interventions (4), thus being cost effective as well as clinically safe and effective.

However, successive government policies in England have underfunded General Practice and undervalued continuity of care, by favouring "access" to anyone at the expense of all other values, by promoting a corporate model of GP provision and by promoting "General Practice at Scale". Many GPs have given up and handed back their contracts. As a means of survival many GPs have opted or felt coerced into merging with giant "super practices" of hundreds of thousands of patients. Others have chosen to be employees of large corporate GP providers, being moved from location to location and developing no deep or long-term connections with patients or communities.

nference 2019

What is the Primary Care Network contract?

It is against this background that NHSE has agreed a new GP contract with the profession that claims to address some of the major issues affecting General Practice, especially funding and staffing. One aspect of this new contract – Primary Care Networks (PCNs) – has attracted a lot of attention.

Under the PCN contract, practices agree to link up with other local practices in groups of 30-50,000 to form a Primary Care Network. The PCN contract is an extension to the basic GP contract and is known as a Directed Enhanced Service (DES). DESs have existed for many years and are used by NHS England as a contractual mechanism to get GPs to do things over and above their core contract requirements. GPs had until 30 June 2019 to sign the PCN contract.

The Primary Care Network contract will not affect the core GP contract (known as the GMS or PMS contract) with its registered list of patients.

Practices will keep their individual contracts and continue to be paid the vast bulk of their funding directly through that contract, for providing core primary care to their registered list of patients.

This is a very important point as there has been some misleading messaging being put about that PCNs entail practices merging their whole lists into the PCNs and no longer functioning as individual practices. This idea of practices merging into a bigger organisation was proposed in the Integrated Care Provider (ICP) model, promoted by NHS England (NHSE), whereby GPs would give up their practice contract and patient list and merge into a massive organisation each of which could cover tens or hundreds of thousands of people. KONP vigorously campaigned against the ICP contract alongside We Own It. The ICP contract model is also opposed by the GP profession.

PCNs are seen by many GPs as a way of protecting themselves from pressures to be subsumed into larger organisations such as super-practices or ICPs, enabling them to retain the benefits of smaller scale practice size at the same time as supporting them to work with neighbouring practices to provide a wider range of services.

The PCN ideas of greater collaboration between practices and a wider range of practitioners from different disciplines working in multi-disciplinary teams, working around the patient, have always been valued by GPs and the idea of some extra funding going into this is being seen by many as a good thing.

But PCNs can't and won't solve the problems of General Practice.

They won't solve the shortage of GPs. A wider range of practitioners will not be able to replace GPs because of the nature of GP work. As primary medical care becomes more complex, and more and more work that was previously done by hospitals, is transferred to General Practice there is a need for more GPs, not fewer.

And what about the risks?

Diverting further resource away from GP frontline care

Many GPs fear loss of autonomy from PCNs, especially if in future even more funding is funnelled through PCNs rather than directly to practices, allowing more centralised control and depriving practices of the resources to determine their own ways of doing things.

Some GPs see PCNs as yet another reorganisation taking up precious GP time and wasting resources. Each PCN will take up the time of a GP in the Clinical Director role for one day a week. Across the country, this would be the equivalent of about 270 GPs taken from front line care.

Irresponsible inducements for GPs not to refer to hospital.

The proposal that any savings from reduced A&E usage or hospital admissions would be shared with PCNs is irresponsible and unnecessary. Similar schemes in the past have proved futile and only served to sow distrust in patients towards their GPs – patients could no longer be sure their GP was acting in their best interests.

Improved community care is a good thing in its own right and if it also reduces unnecessary hospital usage then all GPs would recognise that as a good thing – they don't need financial incentives for that – they just need community care to be properly funded.

PCNs and the Long Term Plan

The statement in the NHS Long Term Plan that PCNs will be the 'building blocks' of bigger Integrated Care Systems (ICSs) is a definite cause for concern. This is especially so if ICSs become ICPs, otherwise known as Accountable Care Organisations (ACOs), with all the attendant risks of privatisation, rationing of care and loss of public accountability that KONP has already highlighted.

So what can we do?

PCNs do not affect the basic structure of general practice with its registered patient lists and general medical services (GMS) contract. There is no automatic conveyor belt between PCNs and some bigger, potentially privatised conglomerate such as an ICP. Whether such a thing happens will be the outcome of political forces, resistance and popular struggle. Nothing is inevitable.

It is wrong to suggest that this has already happened – that practices signing up to PCNs entails them signing away their patient lists to a prototype of an ACO and the end of General Practice, as we know it. That would be to say we have already lost the fight when we have not. And to say we have already lost prevents us from fighting effectively to defend what we still have.

We need to look out for the warning signs, such as GPs feeling pressured to give up their patient lists and join ICPs, in the name of integration and collaboration and we should argue that these are possible without ICPs. We should oppose the government's drive towards GP at Scale, which preferentially favours large and corporate practices. This includes ending all support for the Babylon app-based model of general practice.

As well as a significant increase in funding of General Practice, in a context of increased investment in health and social care in general, we need to press for particular investment in doctor, nurse and allied health professional training and in particular, an increase in GP training places.

On the wider political level we need to be campaigning for an end to austerity. Patients for whom difficult social conditions are compounding their mental and physical health problems present a demoralising level of complexity for GPs, given the destruction of local community support services, the hostile benefits system and underlying problems such as poor housing and unstable jobs.

We need a radical solution that recognises general practice as a generalist community based specialism. This means looking at our evidence base and forming policy around what works. We know continuity of care works, so let's start there. We know care is more complex: that problems present in biopsychosocial ways, so let's have practitioners trained in managing those, with sufficient time to spend with patients and knowledge of the community in which they are embedded.

We know that care requires more than just the GP, so let's invest in the primary and community health care team. And, yes, we should have integration and collaboration, but that is impossible in a market based system defined by commercial contracts, so we should be fighting to take the market out of the NHS and renationalise it.

Combining traditional general practice with better collaborative working in neighbourhoods is the best defence against pressures to join ICPs. That is why many GPs have hesitantly supported PCNs.

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(The full text of Louise Irvine's lecture can be seen on the DFNHS website: https://www.doctorsforthenhs.org.uk/the-crisis-in-general-practice/)

Professor Kate Pickett

Kate Pickett is Professor of Epidemiology at the University of York and the University's Research Champion for Justice and Equality. She is Co-founder and Trustee of the Equality Trust and co-authored the influential The Spirit Level, and The Inner Level

Report by Alan Taman

There is more than poignancy in pointing out how inequality affects children. Kate Pickett chose to centre her talk on changes to childhood health and what lay behind it, playing to her undoubted strengths by drawing international comparisons before focusing on the UK.

This is not a happy story. After raising some of the worst aspects of childhood health trends with some damning news headlines on child poverty, Kate showed, with rock-solid epidemiological evidence, how the UK was steadily falling further and futher behind many of the other industrialised nations in overall child mortality trend, infant mortality (Estonia and the Czech Republic now fare better), and Index of Well-Being.

The epidemiology is remorseless. Child Well-being has a strong association with inequality in rich countries and more bullying is also associated with inequality. As is the prevalence of parental mental illness, increased working hours, household debt (reaching for the credit card is now so often not so much a seasonal bind as a perpetual facet of household life – for those who still can), and – a core consideration in the *Inner Level* – status anxiety across *all* levels of income. It continued. Depression was higher in more unequal countries across all income levels, as was self-exagerration, narcissism, and stress and self-harm in young people.

Kate also pointed out that advertising costs (as a proportion of GDP) were higher in more unequal countries. She suggested this was a reflection of the need to impress others.

All quite bleak. But then we heard about the Born in Bradford and the City of Research Project. An impressively ambitious research project aimed at finding out what influences the health and well-being of families, and what can be done to improve them. This was key: finding local solutions which people themselves can engage with.

Kate ended with a series of points that were if anything more thought provoking for members. Childhood poverty was increasing again but perhaps

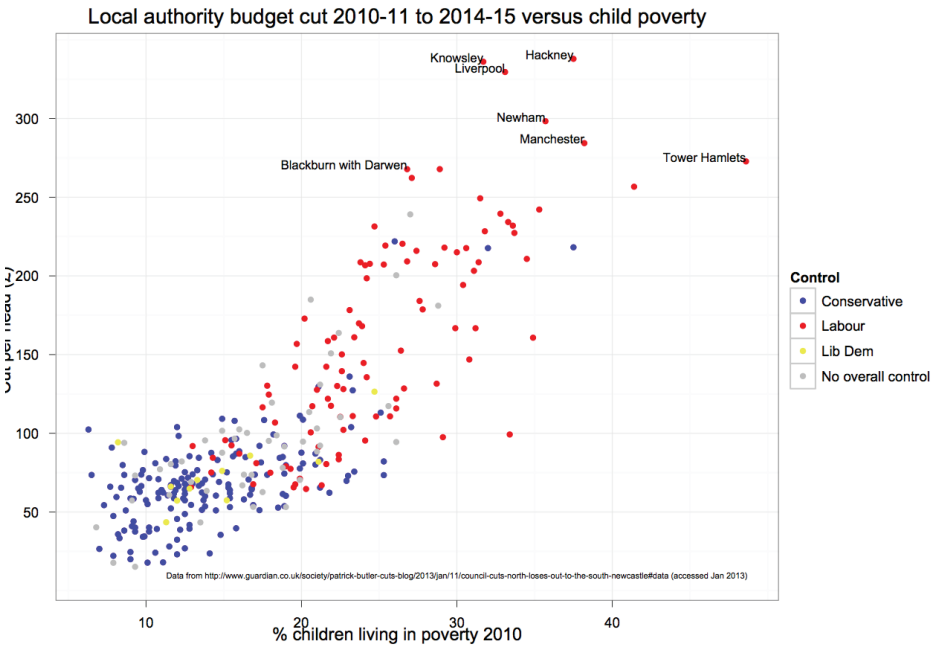

Figure 1

the most interesting picture was for local authority budget cuts when looked at along controlling party lines (Figure 1).

A knee-jerk partisan response might be to blame Labour! The red dots are clustered fairly convincingly. But it does not take much consideration to realise that those very areas with the greatest need – generally Labour controlled – are nearly always the ones suffering the highest cuts. Because, of course, local authority budgets have been placed under immense strain from central governemnt cuts through austerity. Those serving communities suffering the greatest deprivation would have to spend more, so have have had to cut more as central funds dropped. How can this not do anything other than make existing inequalities, with all of their accompanying ill effects on the health of children, even worse? A stark reminder that inequality blights and in some cases shortens lives, but with a message of hope: that none of this is unavoidable, all of it is down to political choice, and what is needed is the political will to make the right choices for our children and young people. All of them.

nference 2019

The Paul Noone Memorial Lecture

"Whatever you did for one of the least of these"

The Most Reverend Dr John Sentamu, Archbishop of York

We were privileged to be addressed by Dr John Sentamu who has experience, over many years, of investigating and speaking out about a wide range of social issues. These have included the murders of Damilola Taylor and Stephen Lawrence, an independent commission on the future of the Living Wage and the impact of multinational oil companies on the environment and human rights in the Niger Delta.

Report by Andrea Franks

In a thoughtful, wide-ranging and inspiring talk, Dr Sentamu spoke on the need to care for all our citizens and the vital contribution of the NHS and social care to a just society. He pointed out too how many other factors also play a part in health in that 40% of health is due to behaviour, 30% to genetic inheritance, 15% to social environment, 5% to physical environment, and only the remaining 10% to health care.

Several 19th century industrialists took practical steps to improve the health of their workers. The Yorkshire chocolate manufacturer Joseph Rowntree, for instance, provided his employees with a library, free education, a doctor, a dentist and a pension fund. Public health measures such as the Clean Air Act, sewerage and sanitation have also played a huge part in improving the population's health.

The title of this lecture comes from St Matthew's Gospel and reminds us of our responsibility to care for all others around us whatever their circumstances, particularly the sick, impoverished and marginalised, and to champion and live out the common good.

Dr Sentamu spoke about three interconnected areas where the NHS and social care have a key role in contributing to a just society.

The ageing population

People over 65 were once considered old, but over a million in this age group are still in paid work. Whether in work or not, it is vital to remain creative and productive in some way, to maintain a sense of worth. How can a just society be maintained for an ageing population?

- People are now prepared to buy into a system which ensures a high level of care for all who need it, and it is good that NHS and social care are becoming linked. For older workers, more flexibility in workplaces would accommodate their changing needs while allowing the organisation to benefit from their experience.
- More contact between generations promotes mutual understanding and the old can be helpful mentors for the young. Dr Sentamu mentioned a care home in York which is adjacent to a nursery school, providing interest and enjoyment

for old and young.

- Care must be holistic and work for the common good, treating each person as an individual with their own differing needs.
- In an ageing population, more people will be living with dementia. It is thought that about 1 in 3 of those born today will ultimately be affected, and we do need to develop policies to support these people and their families.
- Those working in the care sector need our commitment. While many care staff feel a real sense of vocation, their average hourly pay in the UK is only £7.95 an hour, well below the living wage. This must be addressed and workload pressures improved as well as flexibility and opportunities for professional development. Those who care for family and friends, giving up almost 15 billion volunteering hours between them, also need our support and care.
- Death is inevitable for all of us. Hospital chaplains must play a central role in providing spiritual and religious care for the patients and also for the health team. Everyone should be treated with dignity and compassion and there must be quality palliative care.

Mental health

In their book '*The Spirit Level*' our previous speaker Kate Pickett and her colleague Richard Wilkinson ask:- 'How is it that we have created so much mental and emotional suffering despite levels of wealth and comfort unprecedented in human history?' One in four of us now has a mental health issue and although we are now more aware of this, these problems are often hidden from others for many years. There are still problems of stigma and social isolation, but initiatives such as the mental health awareness day can help to reduce this, especially when high-profile people such as the Dukes of Cambridge and Sussex speak out about it.

Dr Sentamu pointed out areas of particular concern in access to mental health care, and to early diagnosis and treatment, for those from Black, Asian and minority ethnic (BAME) communities. Black men may feel it 'unmasculine' to admit to mental health symptoms, while Asian people, particularly women, may not seek treatment because they fear it could bring shame on the family. In all cases, there must be timely access to clinicians, accurate diagnosis and appropriate treatment.

- Advocates from the BAME community who would speak out and champion mental health would help to reduce feelings of shame and stigma, which would help early access to treatment and so cut down the tendency for mental health problems to pass down generations.
- A lack of cultural understanding, and sometimes racism, has led to more BAME individuals being subject to compulsory detention under the Mental Health Act, and this causes distrust and fear. Better education and understanding of cultural differences is vital, as well as dealing with any hint of racism.
- BAME individuals and communities must realise that failure to seek treatment for mental illness is extremely damaging to the affected person and to their wider family.
- Religious organisations can play an important role as they are often perceived as trustworthy and independent, and can act as 'honest brokers', with networks which can be used to help to design and deliver culturally accessible and appropriate services. Religious leaders often use phrases such as 'healing of body, mind and spirit'. Psychiatrists may tend to dismiss the importance of this, but the spiritual is a vital part of the whole person and must be treated as such.

Mental health problems are common among all groups. A recent survey of 4,500 adults showed that 13% had experienced suicidal thoughts

because of concerns about body image, and 10% of UK women have deliberately hurt themselves because of such worries.

Dr Sentamu urged us to be 'the light, hope and help for those who need it most' in what can seem a very dark time for an individual.

Collective responsibility for our health and wellbeing

The NHS and social care have a part to play in individual wellbeing, but many other factors play a part, and a holistic approach is needed.

We must move towards a more equal society, as inequality within a society worsens people's health. In Michael Marmot's book *The Health Gap* (2016) he highlights this and states:

'Inequality often means disempowering, it deprives people of control over their lives. Their health is damaged as a result. The greater the disadvantage, the worse the health'.

The Office of National Statistics in 2013 showed, for instance, that men born in Kensington and Chelsea can expect to live 10 years longer than men from Manchester. Even within the same city there are differences, with life expectancy of those from the poorest parts of York about 7 years less than people from the richest areas. We cannot accept this state of affairs.

Care must be integrated and holistic and aim to reduce inequality. We should encourage community life and volunteering schemes, with every part of society, including religious organisations, contributing to discussions about health planning. Everyone should have opportunities to fulfil their potential, and must be cared for if they are unwell.

We are responsible for our individual choices, such as exercise or choice of food, which affect our wellbeing and that of others and which can affect the costs to the NHS.

Our contribution to the NHS and social care requires us to pay taxes in proportion to our ability to pay and to see this as an investment which contributes to the common good, not as a payment for services received. Ultimately, however, the common good 'is created through individual acts of kindness, care and compassion for others known and unknown'.

Dr Sentamu reminded us of the story from St Luke's Gospel of a compassionate and neighbourly Samaritan, and of Jesus' instruction to 'Go and do thou likewise'.

We should:

- create a more equal society
- take care of ourselves and others
- adopt a collective community approach, driving change for the future.

Long-term planning is needed as we cannot achieve everything as early as we would wish.

The common good is for everyone, with compassion, humility and justice, and the dignity of each person, at the forefront of our actions.

Dr Sentamu closed with a quotation from Michael Wilson's book *Health is for People*:

> **'Health is not for the rich to give to the poor. Health is a quality of life they make together. Neither can possess health apart from the other, nor steal health from the other without robbing himself. Rich and poor, doctor and patient, oppressor and oppressed make one another, We make health possible for one another'.**

(The full text of Dr Sentamu's lecture can be seen on the DFNHS website: https://www.doctorsforthenhs.org.uk/whatever-you-did-for-one-of-the-least-of-these/)

The BMJ Essay Competition: Our profession in today's NHS

DFNHS in association with the BMJ ran an essay competition over the summer, open to Juniors, with the title 'Where have all the doctors gone – and why?'. This is the winning entry

"What's your usual coffee schedule?", I ask my expensively dressed Lawyer friend.

"I'd say it's probably one or two a day. I'm addicted, hahaha", this haughty laugh pierces my eardrums as I glance down at the Patek Phillipe on his wrist.

He politely returns the question "And yours?"

"My strategy is to get a hit as soon as I possibly can……and then simply keep consuming at every available opportunity until I can go to bed". I muffle a silent acid-reflux burp. Overly-busy shift work, out-of-hours studying, and depletion of emotional resources sum to a deep fear that I will lose the battle of wakefulness to the A1-receptor-binding of adenosine.

Like almost every other doctor I know, I am proud to be in a caring profession and to work for a healthcare system that is based on need and free at the point of delivery. I believe the right to free healthcare is the basis of equal opportunity and therefore social mobility. But to be a doctor in the UK today is relentless, it seems to require nothing short of pure altruism.

Allow me to indulge in this pity party for just a little longer. Compared to my peers from University, I am much less financially rewarded (3 to 5-fold), work longer hours, and carry a higher emotional toll. My 'breaks' include skulking away to a grotty doctors' office and staring blankly at a series of stains to distract from any existential angst. I wolf down a snack, trying my best to ignore the numerous smells from the rancid fridge food, the BO infused walls (how?), and a coffee-stained blanket slung over the back of makeshift bed from some poor soul's night-shift.

On shift we do not have the luxury of camaraderie, there isn't time. We barely know who we are working with. It is frustrating to lose vital opportunities for those serendipitous teaching moments on the now-mythical 'Quiet Night'. Fundamental questions include the following: Why am I STILL using a fax machine? Why is there never any paper in it? And why is the paper refill cupboard locked? I spend valuable minutes desperately searching for the King or Queen of keys, worming in and out of patients who sombrely lay on beds in the corridor. This is the apocalypse with 1970's technology.

It is imperative for a doctor to hone their decision-making skills in order to optimise care and facilitate patient autonomy. The irony is, doctors are required to relinquish decision making capacity in their personal lives. The system decides when holiday is appropriate, when study is allowed, even where I end up living within the parameters of the entire UK. There is a constant delay on any 'adulting', such a buying a house, getting married and having children. I have even been told, 'if you are not divorced by the time you take your FRCS, you probably didn't work hard enough'.

It is an undeniable and frightening fact that the number of doctors leaving the NHS has increased in recent years. Since 2011 there has been a downward trend in the number of FY2 doctors moving directly from the Foundation Programme into specialty training in the UK. The latest report shows only 38% go from FY2 into specialty training

(FY2 Career Destinations Report, 2018). Attrition rates are certainly not limited to junior trainees.

Currently in the UK, 1 in 5 doctors who enter specialist Obstetrics and Gynaecology training leave the programme before completion (Gafson et al., 2017). Meanwhile GPs are facing a 'workforce crisis', with a recent survey of 2,248 GPs in south-west England reporting 37% feel they are at a high likelihood of quitting, 36% of taking a career break, and 57% of reducing hours within 5 years (Campbell et al., 2019).

It is all too easy to see why doctors are leaving. According to a 2018 NHS-led survey, 1 in 4 doctors struggle with their workload which leaves them feeling burnout to a high or very high degree. Burnout is known to be a major problem in workplace environments today (World Health Organisation, 1998). It has previously been thought to affect up to 40% of doctors (Henderson et al., 1984). This year's BMA quarterly survey reports 39% of respondents describe their morale as low or very low. Burnout itself has recently been categorised as an 'occupational phenomenon' by the World Health Organisation in the 11th revision of the International classification of Diseases (ICD-11). The ICD-11 definition is of a health issue resulting from chronic workplace stress not successfully managed. It is composed of three dimensions; 'energy depletion', 'feelings of negativism or cynicism related to one's job', and 'reduced professional efficacy'.

With morale at an all-time low, where have our doctors fled? Understanding this is the first step to achieving higher rates of retention. Perhaps they continued their noble profession in shinier and brighter countries, with easier access to coffee? Maybe they jumped ship to non-medical jobs such as teaching, science, or medical consulting? Is it possible they are trekking the Himalayas or completing Yoga teacher training in Kerala? Actually, all of these seem correct! Table 1 shows where all the junior doctors have dissolved to in the last year, with figures re-calculated from those provided by the FY2 career destination report.

Surprisingly there is relatively little detailed research into doctors' motivation for leaving. Perhaps the cornucopia of complex reasons makes for a daunting qualitative (as well as quantitative) research task. Let's start with the basics we can quantify: Doctors at every stage are working outside normal hours. GPs are hit the worst with 75% working outside hours often or very often (2019 BMA quarterly survey).

Secondly, a key feature of discontentment amongst doctors lies in the mismatch between government focus and the concerns of doctors in the healthcare infrastructure. Doctors select their career for altruistic reasons. So it is unsurprisingly demoralising when 85% of doctors have no involvement in planning how healthcare systems in

Table 1 Where have all the doctors gone?

Reported career destinations given by those FY2 doctors not remaining in the UK as a clinical practitioner (No of workers taken from FY2 Career Destination Report 2018)

	No. of worker	% of worker
Career break	921	32.35%
Still seeking employment (likely as doctor in UK)	472	16.58%
Other appointment in the UK (including clinical teaching fellow and military postings)	432	15.17%
Service outside the UK	340	11.94%
Other appointment outside UK	214	7.52%
Still seeking employment as a doctor outside the UK	174	6.11%
Further study	148	5.20%
Turned down specialty training in the UK as location unsuitable	73	2.56%
Permanently left profession	23	0.81%
Undecided/no response	50	1.76%

their local area can meet government long terms plans. In addition, government-imposed targets hang over physicians like a Damocles sword. For example, only 1% of doctors think the 4-hour target in A&E is 'useful', with 31% believing it has a negative impact (2019 BMA quarterly survey). What hope do we have of salvaging a dying NHS when doctors on the ground do not feel heard by whatever incarnation of health minister is currently in charge. To be a force for change we (doctors, managers, politicians) need to be a cohesive unit all working together under a unified philosophy for the betterment of patients. Preferably that philosophy does not include backdoor privatisation, or a policy limited to the convenient length of 5 years. At the very least, given Doctors often have the clearest view of the situation on the ground and always have patient interests at heart, there should be simple and transparent mechanisms in place for us to influence policy and the objectives of managing systems.

Our haemorrhaging workforce is likely due to more than idealistic goals and long hours. A qualitative study of GPs found that fear of litigation was particularly poignant for our primary care doctors, along with feeling as if their position in the healthcare system was under attack. The final factor forms a more universal reason shared by many sub-specialties and juniors; the feeling of being devalued as an individual, and want of a better financial and domestic situation (Sansom et al., 2018).

Meanwhile there are 'pull factors' drawing us to antipodean adventures. One study of UK doctors working in New Zealand demonstrated a much more favourable work-life balance. Mean job satisfaction stood at 8.1 out of 10 (95% CI 7.9-8.2) compared to a significantly different 7.1 (7.1-7.2) in the UK. Free time for leisure was rated on a similar scale, with the doctors in NZ scoring 7.8 (7.6–8.0), compared with 5.7 (5.6–5.7) for the NHS doctors.

31% of the 2000-2005 cohort cited disillusionment with the NHS compared with just 15% of the 1990s cohort (Sharma et al. 2012). In keeping with this, a structured interview study showed Australian working environments were perceived as friendlier with a better lifestyle by those doctors wishing to leave UK (Smith et al. 2018).

Additionally, alternative routes for healthcare and wellness provision are expanding, ranging from social media doctors to life-coaching to tele-GPs and radiologists. For example, the lucrative and more flexible career of health-coaching has been thrust into the foreground often displayed on Instagram (where just one post a day keeps career regression at bay), as well as being highlighted as a legitimate career option by alternative medical career information sources such as Medic Footprints. From this you have the option to tailor your own career, be part of a happy-go-lucky community, and gain back some autonomy. This can play into aspects of functional medicine as much or as little as you choose.

Each specialty has their own myriad of issues and reasons for mass exodus, but there are certainly common threads. Doctors are stepping away from UK training due low morale and burnout. This is as a consequence of the poor lifestyle and work-life balance doctor's feel they experience in the UK, coupled with dissatisfaction with the governmental management. Elsewhere offers the promise of a better lifestyle, glamorous work days and better pay.

There is light at the end of the tunnel in the NHS. I believe we care about our workforce enough to find a solution. Firstly, for the most part doctors intend to return to the UK. The majority surveyed in a recent study of New Zealand-based doctors saw their decision to leave as a temporary break (Smith et al. 2018). GMC data suggests that the majority of doctors that do not immediately enter specialty training following Foundation years, do enter training within 3 years of completing Foundation (F2 career destination report 2018). Secondly, we can ameliorate the issues we currently face. Together we can raise morale and

better the working conditions of doctors. Going forward we have to figure out how to manage public expectations of the NHS. We must learn to ride and tame the tiger of an unruly government so that it works with and for us. We can increase the number of doctors wishing to take managerial positions, develop flexible working hours for those in less-than-full-time roles, and last but most importantly, learn to take better care of ourselves and each other. There's a tough road ahead with an ageing population, raised public expectations, and more tests and treatments available from which we must select.

This all increases the burden on an already crumbling infrastructure. But our wellbeing is no less important than those for which we care. In order to make this an appealing work environment we can no longer be forced into an abusive relationship with the NHS. Retaining our army of doctors in a respectful way is tantamount to keeping our NHS. As is so commonly (mis) attributed to Bevan:

> **"The NHS will last while there are folk left to fight for it."**

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Sarah Marie Farrell

EXECUTIVE COMMITTEE : Elected at AGM 2019

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

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

Dr A. Baksi
General Medicine/Diabetes,
Isle of Wight
baksi@baksi.demon.co.uk

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

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

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

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

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

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

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

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

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

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

Dr M. R. Noone
(Secretary)
Microbiology, Darlington
01325 483453
malila@ntlworld.com
Dr M. O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

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

Dr P.N. Trewby (Treasurer)
General Medicine/
Gastroenterology
Richmond, North Yorkshire
01748 824468
trewbyp@gmail.com

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

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

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

Dr David Zigmond
General Practice (ret'd), London
info@jackireason.co.uk

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

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