DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

Slaves to metrics? Medicine is more than money – Page 3

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NHS Morale Needs More Than Money

Heated debate about how and how much to fund and resource our NHS continues, rightly, to rage. Yet in this contentious heat are we often blind-sided to another aspect of our problems?

The election at the end of last year provided, at least, one area of consensus: all parties agreed that considerably more money was needed for our beleaguered and overstretched health services. The electorate was subjected to a kind of beauty contest with the competitors vying for the biggest endowment. Who would finance most? Who would procure most?

All debate seemed to assume an unquestioned premise: that our current major NHS difficulties can be mostly reversed and remedied merely by increasing finances, material resources and staff numbers. So this is now a common assumption, but is it correct?

There has long been evidence, now growing, that while the marshalling of management and resources is certainly necessary, it is rarely sufficient. Yet it seems that, while many of us have been clamourously, and rightly, arguing for more direct finances and influences – crucially free of the sully and fragmentation of commercial interest – we have all too often lost sight of other things equally important.

So what is slipping beyond our communal attention, grasp and influence? Another view indicates that in our battles over money, measurements and management we have (often unconsciously) selectively neglected that which cannot be directly bought, measured and managed. This neglect, and sometimes designed destruction, has led to losses now very evident and common, but nevertheless bewildering and discombobulating. How and why are so many of our NHS doctors and nurses so unhappy and demoralised in their work? Is it not because, in our determined pursuit of systems-efficiency, standardisation and cybernation, we have eschewed the vagary and heart of the human? Neglected our better human sense and sensibility?

What does this mean? Rather than here argue with more abstractions let us consider the voice of this 36-year-old female GP, Dr S:

> 'I've just had my second child and I just didn't want to go back to work … I never thought I'd say that because I was inspired by how my now-retired Dad had loved his long career as a GP, and it's what I always wanted to be … I wanted to follow him.
>
> 'But the work has changed utterly, from being a local, friendly people-place to being like a giant call centre or distribution warehouse, or something…
>
> 'What do I mean? Well, our small practice was pretty much forced to close and to then amalgamate with several others into a much larger building where almost nobody knows anybody … No, really … the place is enormous, very busy and full of so many different kinds of health-workers – not just GPs – and office staff. And most of the doctors are now very part-time and seemingly short-term … and even if they're not I don't have time to talk to them like I used to…
>
> 'You see, we now routinely see more than 20 people in a session, and that's before possible emergencies and computer tasks and they want me to vacate the room within 3 hours, to prepare it for the next clinic.
>
> 'Most of the patients now I've never seen before

and usually won't see again. So you've heard the directives? Yes, that's right: "One patient: one complaint; ten minutes." So this vast centre is crammed full of driven, anxious, frustrated people who know one another less and less, whether they are patients, colleagues or other staff. What a strange mixture of bustle, crowding and loneliness!

'And that's not all. I haven't mentioned all the controlling compliance regulations and meetings that license us for the privilege of working in this way! … all the Logs we must keep, Professional Development Plans, Appraisals, Inspections, Audits, Contractual tenders, CCG meetings and documents … have you had enough?!

'My father finds it difficult to understand or believe what his old profession has become. "Why isn't there a revolution?", he asks.'

Here is an answer to this question. It is because many of our doctors are now suffering from the Zimbabwe Syndrome, a pattern articulated by a recently-exiled Harare citizen a dozen years ago. He was asked then why the population there remained so stable in its stoic submission when ruled with such oppressive privation, corruption, and heedless incompetence.

He replied:

'Look, we're very weary and live with chronic fear and powerlessness. We just want to keep our heads down, survive and keep out of trouble. If we've got a paid job of work, food and shelter for ourselves and our family, then we're grateful! We don't want to risk any of that. We've seen what can happen to those that do…'

It is an extraordinary turn of history that brings the consequences of reforming a First World's Welfare services to in any way resemble the civic problems of a (now) Third World dictatorship.

The fact we are doing this under the guise of caring better for others can only add to the poignant yet dangerous bathos. And yet, remarkably, the perverse course of this evolution excites almost no interest or debate compared with the devotion secured for sheer money and resources.

Is help at hand with the next tranche of reforms? For example, will General Practice now be helped by the vaunted federations of Accountable Care Organisations (ACOs), Sustainable and Transformation Partnerships (STPs), Primary Care Networks (PCNs) or Direct Enhanced Services (DESs)?

Dr S was asked about this. She replied:

'Oh no! I don't think these kinds of things will help at all to restore General Practice to be the kind of work I find really satisfying and enjoyable … how will any of this provide patients with the kind of accessible and personal service so many of them want … and need? It'll be quite the reverse!

'Why? Well, everything will become even bigger, more bureaucratic, more procedural, more impersonal, more remote … the idea of really getting to know people, their families, their stories, their neighbourhoods will become a kind of nostalgic irrelevance … so my love of personal doctoring in General Practice will become extinct, a historical curiosity.

'If I and the NHS are still here in 5 years – and together – I'll be working in something more like an airport. Will I want to do that job? I doubt it …'

Money may buy short-term Locums, but money can't buy you vocational love. Culture needs more than just cash. Much of this DFNHS Newsletter portrays further what some of these needs are.

In particular, and unusually for this journal, we publish an article using vignettes to illustrate our concern. *Fallacies in Blunderland* was written from the front line of general prractice in 2012 but its observations and accuracies have surely grown in relevance since then.

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View from The Chair
Plus ça change, plus c'est la même chose?

The impact of the General Election in December 2019 means that the parliamentary landscape in which the NHS in England finds itself, is unlikely to change much for a number of years.

That certainly does not mean that the working environment and the way in which patients experience treatment will not change – far from it. This is bound to influence the tactics and priorities of DFNHS and other health campaigning organisations.

Matt Hancock is still Secretary of State for Health and Care and Simon Stevens, newly knighted, is still Chief Executive Officer for the NHS in England, so we can expect many of the previous themes to continue, including the development of Integrated/Accountable Care Systems/Organisations and huge capital investment in information technology systems and support for online medical consultations. What can we gather from pronouncements thus far?

Conservative Election Manifesto 2019

There has been considerable argument over the real value of the funding settlement and the pledges to increase staffing levels, and political pressure needs to be applied to ensure that these commitments are delivered, both in numbers and in spirit.

Similarly, the statement that "When we are negotiating trade deals, the NHS will not be on the table. The price the NHS pays for drugs will not be on the table. The services the NHS provides will not be on the table" is open to a range of interpretations. Many large American corporations, or their subsidiaries, such as McKinsey, Optum, Kaiser Permanente, IBM and Cerner are already deeply embedded in the NHS and have been for many years and are now among the suppliers accredited by NHSE to support the development of integrated care systems. They have consistently influenced policy development to bring the working and structures of the NHS in England more in line with those of the USA, and further away from other models, such as those of Scandinavia, for example. We might expect more of the same.

Some pledges are more clearly defined, such as the welcome reintroduction of maintenance grants for students of nursing and professions allied to medicine, albeit between only £5000 and £8000 per year, and also help towards childcare costs, although tuition fees remain. The introduction of an NHS Visa and fast track entry system is proposed for qualified doctors, nurses and AHPs from overseas, and their families, but at the same time, an increased NHS surcharge paid by people from overseas and continued scapegoating of supposed large numbers of 'health tourists.'

As for our social care system, which struggles under the impact of austerity policies disproportionately borne by local government, there has been no policy guidance from successive governments over the last 10 years, because of reluctance to accept well-considered reports such as that from the Dilnot Commission in 2011. The long-awaited Green Paper has vanished: now, despite the commanding parliamentary majority enjoyed by the Government, there is only a suggestion for cross-party discussions. The impasse continues to take its toll on those in need of care, care workers, and friends and family, as well as contributing enormously to capacity problems in the NHS.

The Queen's Speech December 2019

The removal of the Secretary of State's

responsibility for provision of the NHS, in the Health and Social Care Act 2012, means that we need to consider not only the policies announced by the Government, but also those coming from the quangos that are 'at arm's length' from the Government, especially NHS England. Some of what we might expect can be divined from the Queen's Speech.

Within the first 3 months the Government wishes to pass an 'NHS Funding Bill', to enshrine in law the funding settlement for NHS England up to 2023-24. Ostensibly, this is to provide a secure basis on which plans can be drawn up and delivered, but it also constrains any flexibility to increase funding, should the current settlement prove inadequate for the demands placed on the service. No mention of a settlement for Health Education England, which is responsible for training budgets, and which has had flat-line funding in real terms for many years.

In addition, NHSE has found that their vision for Integrated / Accountable Care is incompatible with a number of aspects of Andrew Lansley's Act and that legislative changes would make their task much easier. They held a public consultation on this last year, but the Election got in the way of any legislation. The Government has stated that it will 'bring forward detailed proposals shortly.' DFNHS has been strongly critical of previous attempts to promote Accountable Care Organisations. We will look carefully at any proposals for legislation that would enable such organisations to be set up and may well call on individual members to lobby their own MPs, of whichever political stripe, if such concerns appear justified, as well as lobbying as an organisation.

We saw, once again during the General Election, arguments about definitions of 'privatisation' and 'selling off', which absorbed precious minutes of airtime and column inches, which could have been better spent in the exploration of the corrosive effect of the profit motive on the provision of professionally delivered universal healthcare.

Apart from the sale of publicly owned land and buildings, and specific instances such as the sale of UK Plasma, most companies prefer to extract as much public money as possible through commercial contracts, with most risk being borne by the tax-payer, as has been very clearly demonstrated in the Private Finance Initiative fiasco. There might be benefit in using a term such as 'commercialisation' and steering clear of 'privatisation' in future public debate. It would probably fit better with the experience of most members of the public who tend quickly to lose interest in debates on semantics.

What about NHS England?

> "Most companies prefer to extract as much public money as possible through commercial contracts, with most risks being borne by the taxpayer."

Last year's NHS Long Term Plan contained dozens of proposals that were entirely dependent on improved levels of staff in many disciplines. We were supposed to see an NHS People Plan outlining the strategy that would underpin the commitments in the Plan during 2019, but its release has been delayed and it will probably not be published until after the Budget: probably in March or April. NHS organisations are returning 70% of their Apprenticeship Levy contributions to the Government, as they have not found a way to make use of them for the intended purpose. This points to the need for a serious rethink of the apprenticeship scheme.

The last two issues of this Newsletter have expressed differing views of the risks and benefits of the Primary Care Networks (PCNs) that have been set up across England. The rejection, by the BMA, of this year's contract for participating GPs and its subsequent revision, does suggest that the expectations of this reorganisation are too great

and are coming up against the reality of hopelessly inadequate staffing levels and other resources. We will be seeking the views of GP members as to whether there is a particular stance that DFNHS should take on PCNs.

Last year, NHSE placed restrictions on doctors performing seventeen 'Evidence Based Interventions', or 'Procedures of Limited Clinical Value'. There was much opposition to this interference in the freedom of doctors and patients being able to determine, between themselves, the best course of treatment to pursue. It was feared that this would be the thin end of the wedge in the definition of a less than comprehensive NHS, akin to the list of exclusions in typical insurance policies. As anticipated, a consultation on a further tranche of such 'interventions' was planned for later in 2019, but was pulled because of the snap election. We will keep our eyes open for its re-emergence.

NHSE issued its Planning Guidance 2020/21 at the end of January. In the best tradition of command and control systems, this instructs all NHS bodies in the actions that they are to take. It is interesting to see further recognition that the reduction in bed numbers in the NHS has gone too far – at last the scales might be falling from their eyes! The 3,000 hospital beds that are opened to cope with 'winter pressures' are now to be kept open year-round and bed occupancy reduced to 92%. This is still much higher than the 85% bed occupancy that would permit efficient flow of patients through care, without the bottlenecks and the distress of unplanned transfers of patients between wards, and even hospitals, for non-clinical bed-management reasons, but it is a step in the right direction.

Pressure is being applied to Clinical Commissioning Groups (CCGs) to reduce out of area residential placements of people with learning disabilities. An appropriate member of staff from the referring CCG will have to visit all children every 6 weeks and adults every 8 weeks, to make sure that they are receiving good care and assess whether they could be looked after closer to home. This might focus minds on improving the capacity of local services.

There has long been a tendency for CCGs, and their precursors, to raid funding intended for mental health services, to support the demands of acute medical and surgical services. Now, if the mental health investment standard has not been met during 2019/20, the shortfall has to be made up during 2020/21. It will be interesting to see the impact of these instructions in meeting the imbalance between mental and physical health services.

At the top of the agenda, or a close second

Despite efforts to make the election campaign centred on one single issue, the NHS emerged inconveniently, time and again, as a major concern of voters. The level of debate amongst politicians often demonstrated a depressingly profound ignorance of key issues, but it was clear that the general public still holds dear the principles of the NHS. We need to work alongside the other campaigning organisations to make sure that the public are not betrayed but, as doctors, we are obliged to make full use of our privileged position, and our professional experience, to make sure that this country continues to benefit from that vision of universal healthcare that is as valid now as it was in 1948. DFNHS exists to make our combined voice stronger and louder – now is the time to use it, to convince not only the policy-makers and opinion-formers, but also our professional colleagues, that this struggle can still be won, and is worth the effort.

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Fallacies in Blunderland

Overschematic overmanagement: Perverse healthcare

For more than 20 years there have been various devices to create an internal market central to the NHS: Fiefdom-like Trusts, commercial-type commissioning, contractually defined 'purchasers' and 'providers' of healthcare are current examples.

The resulting commodification and commercialisation of healthcare has become its own culture. What does all this look like at the frontline? The following authentic vignettes from General Practice provide a view. Only usual devices of disguise subtract from accuracy.

The first two tales are now commonplace and superficially trivial, but they already contain the possibilities of bureaucratic burden and distortion that make the shocking last two stories more understandable.

Trivial tales: serious themes

A The Loop

Dr T receives a letter from Mr O, an orthopaedic consultant. It is about Sheila, a healthy spirited woman of 40 who sustained a severe and displaced fracture of both bones of one ankle. She required surgery to realign the distorted bones, then plates and screws to secure them. All of this has gone well, but several weeks later her ankle remains painfully stiff. Sheila will need physiotherapy. Will Dr T please refer her?

This is not as innocent or straightforward as it may seem. An historical explanation:

Several years ago, before the fragmentation of our national service into parochial Trusts, such collateral work was usually done with speed, accuracy, ease, friendliness and very little, but essential and useful, documentation. Mr O would have spoken to his well-known Clinic Physiotherapist, Carol, and said, in effect: 'Carol, this is Sheila (and her problem) that you can help by doing "X". Let me know if there's any unusual difficulty. I'll see her again in 6 weeks'. Dr T may have been informed, but not involved.

Recent times and ideologies have moved to more complex procedures. Trusts now mistrustfully contend and vie, sell and buy. Mr O now has no such sensible and 'homely' arrangement with his physiotherapist (or anyone else). The commissioning health-economy mandates that fragmentation of services is introduced to generate extra revenue for his Trust. Thus Physiotherapy is now separately tariffed from Fracture Orthopaedics. Mr O must now write to Sheila's GP, Dr T, suggesting that Sheila be referred back to the hospital for Physiotherapy. Although Mr O is far better placed than Dr T to make this decision and to implement it, the new commissioning system disincentivises this. This is because the interposed administrative loop 'earns revenue' for his Trust, by 'selling' necessary physiotherapy services. This added complexity helps ensure the financial viability of the fiefdoms.

What does this mean? A short link is turned into a long loop: it is not just Dr T's professional time and attention that are distracted by this unproductive artifice – this must now involve clerks, IT coders, contract administrators, accountants, auditors. Such long threads lead to tangles, so Personnel and Contract Managers and Lawyers must be added.

The aggrandisement snowballs: physiotherapy must now present as more arcane and formidable. Mr O cannot simply make a colleagueial (if highly competent) request: such must be replaced by detailed referral forms, team referral meetings, documented referral thresholds and criteria, data collection and collation (however specious), the propagation of professional reports that illusion depth through length, and gravitas through the unnecessary elaboration of technical language.

Such seriousness must be suitably framed: Carol cannot simply and quickly decide – from her considerable experience – what to offer Sheila. Sheila must join a waiting list for a long, over-inclusive, formulaic assessment to be performed. This will be documented in assiduous and trivial detail, then sent to Dr T, though Dr T has no interest or use for this. He certainly has not asked for it. However, for the 'providers' of physiotherapy it bestows auras of completeness and complexity: devices of theatrical rhetoric and justification. A new, and now necessary, language of survival: Lebensraum.

Dr T has become an increasing though unwilling recipient of such over-laden and other-agendad communications. He now receives hundreds of e-mails every week whose purpose is not to communicate with him about what he needs to know and what may interest him, but rather to confer some kind of aura of immunity, impunity or importance around the sender.

Dr T, despite many years of diligent, competent practice, remains anxiously conscientious: he reads such letters, warding off an attrition of fatigued alienation and … resentment. He hankers for a previous era of more straightforward communications from colleagues who wrote pragmatically of what he wanted or needed to know: a culture where help came from personal connections, not a kind of commercialised totalitarianism. He sighs with unsentimental sadness and sagged purpose. He imagines restitution in early retirement.

B Size 13 Moonboot

Mustafa is an athletic young man, very tall and with large feet. While playing in a football away-match he fractures a metatarsal bone in his foot. He is seen by the accident doctor at the home counties hospital (HCH) who says to him: 'It's a straightforward minor fracture: your body will slowly heal it, but you'll need a Moonboot for several weeks to get around. You've got very large feet: unfortunately we don't have any size 13 in stock. But you live close to the large London hospital (LLH): they are bound to have some. Just go along to their accident department and they will fit you up. It will be quite straightforward …'

That was true until recent years. It is now very different.

Mustafa goes to the accident department of LLH. After a long wait he is curtly told that as this is not a fresh injury he will need a referral from his GP, Dr T. Mustafa sees Dr T, tired at the end of a morning infiltrated and obstructed by such bureaucratic formalities and ritualistic documentation. Dr T writes a clear request for the Moonboot and a routine follow-up, with an equally clear and concise account of the background problem. Until the recent past this would have been responded to in kind.

Not now.

Mustafa reattends LLH accident department with Dr T's letter. A triage nurse peruses it briefly before consulting a Manager. She returns to deliver an accurate slow-spinner: Dr T is bowled-out with her first ball: 'Your doctor and HCH obviously don't understand the system. We can't just give you a Moonboot. You have to be formally referred to Orthopaedics, and then a proper assessment has to be made by a Specialist…'

Dr T had not really understood the concepts of a 'purchaser/provider split', 'Commissioning' and related notions to focus and facilitate healthcare. He is learning now as Mustafa's agent, in these shuttlecock exchanges between Trusts: through these frustrations he is becoming familiar with the

procedures, language and protocol.

What he has not learned – what he cannot see – is the value of all this to his patients, or his own efforts on their behalf. Amidst his many conversations – seeking to clarify the benefits of such systems – he talks with Dr Q.

Absurd but true: A corrupt cadenza – how the schematic becomes perverse

Dr Q is, like Dr T, a stalwart member of an older but dwindling species: a single-handed, vocationally-motivated, psychologically-minded family doctor. He is a quiet man of understated but sustained and sustaining warmth and laconic humour. Professionally close, in both geography and ethos, Drs Q and T meet for companionable support, ventilation and experienced guidance. Dr Q listens, and identifies with bemused and increasing frustration: he has experienced his own varieties of The Loop and Moonboot.

'I've got one to appal and amuse you … Yes, both! … But I have to be careful who I tell …' says Dr Q, teasing gently with competition and conspiracy.

He talks of one of the many institutional directives attempting to raise the standards of practitioners and practices. Most such devices are now measured, scored and complexly linked to remuneration. He is describing one yoked to substantial (written) complaints from patients. Each practice must now show evidence of how it responds to the complainant, and then turns this to positive reflection, learning and changes in their procedure and organisation.

Dr Q slowly unravels his tangle of frustrations: 'Of course, I agree with the better philosophy behind all this: listening, looking, thinking from another's viewpoint; not being too busy, proud or fragile to reflect on, or share such variations.

'So far, so good – but from here it gets worse, for me anyway. You see, I've spent a working lifetime really interested in these complexities. Probably because of that I haven't had any substantial complaint for about 20 years. That's an achievement I'm happy with, but the absurdity is that my practice has lost substantial income through being unable to complete the exercise. For the last few years I have been financially penalised because no one has complained about me!

'Well, my Practice Manager, Muriel, has many abilities but I hadn't realised how she is also a Mistress of Dark Arts. She quietly conjured a miniature masterpiece: she forged a fictitious letter of complaint; invented a practice meeting to respond to this with discussion, reflection and action plans; provided minutes of the (non) meeting, and a summary report for the monitoring authorities. The result of all this? We invent a complaint, because we don't have one, write a long bogus report for an authority that doesn't read it, and then claim the same money as everybody else! Is that a good way to spend doctors' time or NHS money?' Dr Q expresses his rhetorical coda: 'Righteous fraud!', he laughs sharply, a kind of self-parodic cymbal-clash.

> "He shrugs self-consciously, while attempting awkwardly to combine expressions of fraternal collusion with innocent bewilderment. This is difficult."

But now a cross-current of doubt, more hesitant. He clears his throat: 'That's not the way I normally behave, is it? … I mean, what would you do?'

Dr T has not expected this earnest question. He shrugs self-consciously, while attempting awkwardly to combine expressions of fraternal collusion with innocent bewilderment. This is difficult: finding the right formula of words

impossible. He shelters behind an enigmatic smile.

Absurd but tragic: When Care Pathways obliterate care

'I don't think I can do it any more, doctor. I think she needs to be looked after somewhere else ... I'm not as strong as I used to be … I can't lift her, especially if she falls. And now she's much more confused and gets upset in ways that I can't reason with her about … It's so hard, doctor: I think it might kill me …'

Dr T thinks he is not exaggerating: it might. Cyril is aged 99, Iris is 94. They married 70 years ago, a wartime marriage. As a 20-year-old signaller with the Royal Navy protecting the Atlantic Convoys, his hunger to marry Iris had been talismanic as well as romantic: he somehow believed that ritualising the strength of his love would protect him, help him survive. He had, and 40 years later he had described to a young Dr T his then-unspoken war-time terror, and the transcendent power of his faith-in-love.

Iris had been a very attractive younger woman, but ravaged by primitive anxieties: severe early losses and cruelties had been semi-healed by Cyril's loving devotion, but her wounds were shaken open by a late miscarriage. The subsequent birth of a son assuaged but did not resolve. Dr T remembers reading the unusually neat fountain-penned notes of his predecessor, referring to her 'numerous functional complaints' and her 'polymorphous anxiety'. From the 1980s Dr T would help guide Iris through this hazily mapped, apparently endless, medical wilderness. His patience and imagination were his most important resources, but Cyril was his most important ally. For more than 30 years Dr T witnessed the finest manifestations of loving devotion: indefatigable support, humorous affection, practical containment. Cyril was happy in his role of loving protector: Dr T was appreciated for his professional support and guidance. A long period of eddied stability, until the onset of Iris's dementia.

As so often, the dementia was first signalled insidiously and ambiguously, in her ninetieth year. Unsighted by retinal degeneration and unwilling to wear her hearing aid, this frail and slight old lady became increasingly difficult to contact. Her confusion of place and persons was distressing.

"As so often, the dementia was first signalled insidiously and ambiguously ... her confusion of place and persons was distressing ... she would rage at her humiliated disintegration."

Her shards of insight even more so: with angrily tearful eruption she would rage at her humiliated disintegration. Cyril tended her with quiet, soft tears of sorrow.

When Cyril developed his increasingly untreatable heart failure he knew that his tide, too, was running out. 'I just want to be able to look after her long enough, doctor …' he had said with characteristic, stoic courtesy

When Cyril – looking haggard, exhausted and afraid – talks with polite deference of his inability to cope and a premonition of his death, Dr T has no doubt about the need for urgent action. Iris needs immediate respite care. He calls Social Services.

Many years ago Dr T recalls a similarly abject and acutely disintegrating situation, and his similar request. He remembers his meeting and conversations with the Social Worker, Phyllis, a thoughtful, sensible middle-aged woman with maternal warmth and grand-maternal wisdom. Phyllis had been quick and seamless in her understanding and intelligent actions. Dr T had thought that such dextrous and humane holistic engagement had transformed a painfully tragic

situation into one with a kind of elegant pathos. He had felt grateful, moved and proud to be associated with such unglamourised expertise.

Now, in 2012, it is very different. Dr T is phoning the duty-desk Social Worker, Vanessa. He is trying to convey, with intelligible rapidity, the nature of his problem with Iris and Cyril: a brief history and his urgent recommendations. This is turning out to be very difficult. Vanessa clearly has another agenda. Her voice sounds young to Dr T. She transmits it with manicured, polite cautiousness. She explains a protocol which must be adhered to: preliminary screening questions must be completed. Existing Social Services' package? Home OT Assessment? Number of falls? Mental competence? Screening blood tests? Complete Medical and Psychiatric history? Most recent Social Services assessment? Yes, yes, yes … and YES! Dr T attempts to tell Vanessa that a colleagueial dialogue can get to the important points more accurately and quickly. But Vanessa is well briefed and disciplined: she sticks to her prescribed course. At the end of her formulaic collation, Vanessa (who has never met Iris and Cyril), informs Dr T (who has known them both well, for 30 years), that respite care can only be considered after she has been assessed and reported on by 'appropriate' specialist clinics: specifically and separately for her falls, her dementia, her mood instability and her age-related medical complaints.

No, there cannot be exceptions. Dr T – almost incredulous, certainly incensed – asks to speak to Vanessa's manager.

There is a delay. When the manager, Marjorie, calls Dr T she seems to be listening diplomatically, but then, equally diplomatically, seems not to have heard or understood. Yes, no. She understands (?) but must support Vanessa in her correct responses: that is how these situations must be managed. Yes, she can understand Dr T's frustration: 'I'm sorry'.

Dr T does not accept defeat. He makes further phone calls. He will shake some senior sense from Social Services, but is told that the regional Director of Social Services is away for 2 days. He then phones Cyril, whose voice sounds weaker and more short of breath. Dr T asks him about this: Cyril is resigned, self-abnegating, (again) disarmingly accommodating. Dr T refers to administrative delays with respite care: he does not elaborate, but apologises and makes clear he is active in trying to make things happen. 'Yes … Thank you for everything you're doing, doctor … I'll manage somehow.'

But Doctor T does not feel good about this. It is Friday afternoon.

On Monday morning Dr T hears. The carer had gone in the previous day and had found both old people on the floor. Iris was moaning with hunger, confusion and soaked underwear, unable to raise herself. Cyril was beside her, but still and silent: grey-mottled and dead. He had probably been trying to lift her.

Iris was immediately taken into care by Social Services.

Dr T feels immersed in an ocean of sadness: for our human frailty, fallibility, folly, pride and evanescence. His surgery is due to start; he dries his eyes.

The whole is more than the sum of its parts.

Plans get you into things. But you got to work your way out.

– *Will Rogers, The Autobiography of Will Rogers (1949)*

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Whatever Happened to Medicine's Mojo?

Cultural and economic perspectives of the last 100 years

Medicine is ever-more powerful. So why are doctors in the NHS feeling so dispirited and discounted? An outline of healthcare organisation over the last century provides some answers

In October 2019 Archbishop John Sentamu talked to Doctors for the NHS (DFNHS) in a medieval banqueting hall close to York Minster, the centre of his diocese. He told us, I think, not only what he believed, but what he thought these seasoned doctors wanted to hear.

His speech was rich in references and eulogies to a confluence of both Christian and humanistic values – compassion, kindness, belonging, personal understanding and connection … all induced by some kind of universal spirit. His manner was serious and warm, earnest yet lightened with humour. The audience responded with rapt reverence: certainly, he was here preaching to the converted – surely a moral boost, and a boosting of morale, from one who personified the good to the many holding out for something better.

This infusion was both welcome and timely; it was now the last session of the day and the previous speaker – a heroically resilient and remarkably tolerant-though-frustrated GP – had talked of a solid commitment leached by a growing despondence: she described the demoralised unravelling and staffing depopulation of her beloved profession. So the Archbishop's speech, mere presence and aura lifted our plummeting spirits.

As the meeting was formally closed and the microphone switched off there was the inevitable encircling huddle for contact around the Archbishop: gratitude, greeting, homage, flattery … I waited my turn.

A hiatus in the huddle. He turns toward me, with a slight tilt of the head and an extended hand to signal his attention. I introduce myself.

'Thank you. Of course there's a lot of support for everything you say in a meeting like this and, I hope, both ways. Who here is going to disagree? But there's a major problem for us doctors. Believing these things is now easily stymied. You see, our system with its serial reforms makes it ever-more difficult to live by our beliefs, to do them … so eventually they ail and perish …'

He nods with, I think, thoughtful sorrow.

'I know … I hear … it's very hard. What do you think has happened?'

I am encouraged by his question.

'Well, you talk, quite rightly, a lot about care – the heart of your religious and our medical activity. Yet if you talk to any long-serving NHS doctor they will tell you that over their working lifetime, although everything scientific and technological is better, almost everything to

do with personal contact, understanding and relationships is worse. So our treatments are much more effective, but our care has become so much poorer…'

I can see him thinking hard. I venture a question:

'Have you noticed the age of most of the doctors here?'

'I am not sure … why?' he wants to divine the nature of the question: is there an implicit statement? 'What are you getting at?', he says.

'Well, this is a pretty old group, isn't it? I think most of us are retired', I answer. 'These doctors want to keep the spirit – the better ethos – of Medicine alive well after they are no longer doing the work. We want our better essences to survive us, in others.'

He nods vigorously, an emphatic agreement.

'What about the young doctors?', he asks.

'Well, here's a sad, and I think very significant, observation … the young doctors seem too stressed, fatigued and dispirited to invest in these "higher functions": they have enough to do just to do their contracted job, just to survive. I call that the "Zimbabwe Syndrome". I guess I don't have to explain that …'

He shakes his head with rueful recognition and asks, 'Why is that?'.

'Well, as you were making your speech my mind drifted to my profession's plight and then to the evolution of this country's last century of healthcare. I think we can helpfully understand our current problems by dividing the century into three periods. It seems to me that each period had its own ideology, economics and modus operandi. As I can explain, the older doctors here spent their formative years in the second period and now flounder in the third. Younger doctors have no experience of the second and know only this last and third era – these periods are quite different in a way that's very important to understand…'

I falter: I can see my unexplained abstractions have tumbled out faster than he has caught them. But there is another hand on his shoulder, courteously guiding him to attention elsewhere. So what are these three eras of healthcare – the distinguishing modi operandi, the ideologies, the economics – that may help us understand the story of the reform-driven malaise now blighting our services?

Herewith a very brief overview. A century of healthcare: a brief cultural history.

1. Pre-1948: Individual capitalism and charity. Each man for himself

Before the NHS in 1948 most doctors worked among wealthier populations where they could be paid. The poorer and much larger majority of people therefore had very little access to medical help. There were many singular exceptions provided by charities, religious organisations and remarkable proto-socialist doctors – but the overall trend was unmistakable: most doctors worked either for themselves or for small, profitable groups, operating like small independent shopkeepers.

This guild or small-shopkeeper culture may have incorporated some vocational spirit toward individual patients but remained, mostly, protectionist at a social level. That is why most doctors (or at least their representative BMA) fought so hard against the founding of the NHS. At the time it seemed unlikely that doctors would mostly settle with, and for, this revolutionary reconfiguration of their work: many experts then were pessimistic about the viability of this new NHS.

2.1948-c1990: Social and vocational medicine. We're all in this together

Yet the medical diehards so obstructive to the

launching of the NHS were emphatically proved wrong. In hindsight we can now see how remarkable was this unprecedented and rapid reform: within a few years the recruitment, morale and staffing stability of this new service provided comparatively equitable care that developed a quality that drew international acclaim and research, and mostly affectionate trust and esteem amongst our own practitioners and general population.

There were failures, of course: DSRs (duffers, slackers and rotters), both institutionally and professionally – but these were the exception. Most worked with a high degree of colleagueial cooperation, fraternal reciprocity and interprofessional trust. Practitioners and institutions were guided and motivated by an often-unspoken sense of social vocation. There was little (if any) reference to contracts and no inspections, commercialised competition or commissioning, or metricised appraisals.

This 40-year period may, from today's perspective, seem remarkably lax, unincentivized and unmanaged. In a way this is true. It is also true that demands and expectations were then lower. Even so, most veteran practitioners would say that this pre-1990 period was one of greater work efficiency due to its better personal relationships, trust and morale. And then the more seamless and synergistic relationships that could flourish between its operational groups.

We all had a clearer sense of belonging with, and belonging for.

A good-enough system, surely? So what happened?

3. 1990-present: corporate capitalism and micromanaged medicine

The system will decide.

In short, this last and current period can also be denoted by healthcare via the rising culture of neoliberalism, and systems of cybernetics. Or, in more ordinary language: markets will propel and decide, and computerised systems will micromanage.

Here was a new concoction – a potent mixture of culture, ideology and new technologies that, in effect, said: 'Welfare services cannot possibly provide their best by relying mostly on the personal motivations, skills, relationships and judgements of those who work in them. That is far too capricious and unreliable. We must, rather, incentivise by introducing competitive pseudomarkets. We can further ratchet-up quality and value-for-money by computerised micromanagement. This will instruct and monitor all employees and then, where necessary, sanction or eliminate. We can do this from outside the professions; the spectre of power will soon assure recruitment from within.'

These reforms were first unleashed in the heyday of the Thatcher government, a regime with a quasi-religious belief in the liberation of markets, yet the astringent external governance of Welfare. Despite the increasingly evident destructive effects over these 30 years, each successive government has colluded with, elaborated or amplified these Thatcher-era initiatives.

So what has been the fate of this post-Thatcher, CCMM (corporate capitalism and micromanaged medicine) era? It is mixed, but mostly not good. Most independent investigations conclude that the marketisation has brought inefficient bureaucracy, perverse incentives and 'gamings' as well as mistrustful – often hostile – fragmentation of services. There is little evidence of greater healthcare efficiencies or better motivation.

There has been similar research indictment of the policed regulation and inspection aspects of micromanagement. While the more egregious DSRs may be identified, we create a far greater problem among the rest by generating an alienating and unsustainable environment with an enormous burden and distraction of compliance tasks and bureaucracy. Most healthcarers find this not only unintelligently unhelpful but divisive, dispiriting and exhausting of their limited energies. The net effect, again, has been negative.

Such negative effects can be illustrated by a metaphor: our earlier NHS (era 2: social and vocational medicine) was handled more like a living tissue – with understanding, care, nurturance and protection it would mostly grow to produce a natural synergy and balance between its parts. In contrast, our current NHS (era 3: corporate capitalism and micromanaged medicine) is approached, rather, as an inanimate mechanical object – a motor engine, say – that must be designed, engineered and manipulated to surrender the performance we choose and command. Era 2, a time of greater work harmony and satisfaction, was guided by animate, organic perspectives. Era 3, our current period of commanding algorithms and policised monitoring and instruction, is, contrastingly, driven by considerations from the inanimate, the inorganic.

What has this led to, in human terms? Well, it has yielded us the personally 'homeless', rootless, lonely, fractious no-one-knows-anyone-but-do-as-you're-told culture. Here, now, data and metrics displace personal understandings and meanings; corporation eclipses vocation; nuanced judgement, initiative and colleagueial trust are all needlessly pushed aside by the blunt rigidity of (often commercialised) corporate contracts.

The personal warmth, spirit, élan vitale, reciprocal nourishment and mojo (choose) – the essentials to sustain our difficult work over long periods – is starved and dies. We have removed the metaphorical human heart of human warmth and inclusion, then replaced it with a mechanical heart that can only pump to order.

That is why we now have such serious problems with NHS practitioner morale and then staffing. Money may easily purchase short-term locums: it will rarely secure us veteran vocational practitioners.

A recent cartoon in *The Oldie* is seminal here. Depicted are manacled rows of haggard, emaciated galley-slaves in rags. They look craven and exhausted as their lives depend upon them pulling endlessly on their oars. Above them towers their galley-master: corpulent, massively muscular, menacing and wearing a Roman tunic of office. His right hand brandishes a whip.

'Remember lads', he shouts above them, 'next week: staff appraisals!'.

The cartoonist here, with profound simplicity, brilliantly captures so much of what has gone astray and awry with our NHS, and more generally in our Welfare services.

This comedified wisdom has again and again seriously eluded our serial health-reformers and their political captains (or captives?)

Further reading

1. Sources for this historical analysis and current description of our NHS are numerous and wide-ranging. For reasons of space I have not listed here the many audio, video or paper documents from times past, or the many more current evidence and research statistics from independent thinktanks, academics or government institutions.
2. Further and more systematic analysis of these NHS problems, together with some suggested remedies, can be found in Zigmond, D (2019) *The Perils of Industrialised Healthcare,* The Centre for Welfare Reform.

Interested? Many articles exploring similar themes are available on http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html

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McKinsey Rules OK

The purchasers in the purchaser-provider split

The split was set up in 1991. After nearly 20 years of its functioning, the House of Commons Health Committee on Commissioning in 2010 reported the split to be a "costly failure" [1]. It had led to "an increase in transaction costs, notably management and administration costs" to as high as 14% of total NHS costs. Previously the total administrative costs were 5-6%. These transaction costs very likely became higher following the implementation of the Health and Social Care Act of 2012.

The report states that purchasers had a "lack of clinical knowledge" – there are 65 medical specialities and sub-specialities [2], so the purchasers with one or two GP advisers could not plan strategically for cardiology, orthopaedic surgery, sub-specialities of psychiatry, gynaecology, dermatology, etc. The requirements of "a level playing field" meant that the cardiologists, orthopaedic surgeons ….. were kept at arm's length, despite their having had at least 12 years of high quality general and specialist training in their field. Local leaders felt pressured by central bodies to employ external management consultants [3].

Purchasers were supposed to tailor provider services to meet the needs of the various clinical groups in their areas. The idea that they could know what these needs are is ludicrous. They haven't a clue. Professor Graham Thornicroft of the Institute of Psychiatry and colleagues have measured the area prevalence of major depressive disorder which required a massive research effort and sophistication way beyond the expertise of any CCG – then there is acute and chronic psychosis, eating disorders ….. and that's just in the field of psychiatry.

Furthermore the purchasers didn't have the skills for data management and with constant reorganisations and staff moving, the quality of commissioning was poor [1]. So help was bought in from outside management consultants. Fourteen private sector companies were procured centrally by the DH as FESC, the Framework for External Support for Commissioners. The purchasers could call on these for support. However doing so was bureaucratic and slow, so purchasers often brought in external support independently [1]. In London a single accountant might charge £3,000 per day.

The providers in the purchaser-provider split

In the first quantitative evaluation of the impact of consulting advice on the efficiency of UK public sector organisations, Professor Ian Kirkpatrick of the University of Warwick Business School and his colleagues looked at all 128 acute care Trusts in England [4]. Each Trust was spending on average £1.2 million per annum on external management consultants. Over the four year period of the study, the cumulative cost of hiring the consultants was nearly £600 million. For all the Trusts there was a significant positive relationship between consulting expenditure and organisational inefficiency on the authors' accountancy measures. To this increased inefficiency should be added the cost of hiring the management consultants in the first place, on average £1.2 million per Trust per annum, as mentioned. So much for the unsubstantiated advertising spin that 'for every £1 spent on management consultancy, benefits worth £6 are returned to the client" [3].

NHS England

McKinsey advised on the creation of the internal market in the English NHS [4]. Other well-known accountancy firms worked on Foundation Trust applications, support for outsourcing PFIs and Sustainability and Transformation Partnerships. When the so-called NHS Improvement (NHSI) was set up KPMG was paid £630,000 to work on its 'culture, values and operational model' and two years later McKinsey was paid £500,000 for a report which included clarifying NHSI's 'purpose and operating model' [5]. NHSI awarded Deloitte £400,000 to design NHSE's procurement policy, phase 1. The cost of phase 2 (and possible subsequent phases) is unknown. Seven months after the consultancy was awarded, Michael Hyne, the NHSI's director of procurement and corporate services, joined Deloitte [6]. In 2018-19 NHSE employed on average 6,660 persons and NHSI 1,677 [7].

"This manifests as incompetence of the management consultants, poor quality of their products, overconsumption of their services and levels of disruption associated with reorganisation they advise."

Comment

The deep involvement of management consultants in the UK public sector has been especially marked in healthcare. Provider units, purchasers, NHSE, NHSI and all the bodies set up after the Health and Social Care Act 2012 was implemented have managers on salaries of £hundreds of thousands who at the drop of a hat bring in extravagantly expensive external management companies of unknown effectiveness and which in the case of acute Trusts worsen efficiency. Money for these increased management and administration costs has over decades been channelled out of clinical services and we now have amongst the lowest per capita number of doctors, nurses and hospital beds compared to other first world countries. The NHS might be drowning in debt, but consultancy remains buoyant [3].

Kirkpatrick et al. [4] point to the growing public sector market for management consulting advice, both in the UK and elsewhere. Within Europe, public sector management consulting use constitutes 13% of all management consulting (compared to manufacturing and service sectors), although this varies from 9% in Germany to 22% in the UK. Against the backdrop of New Public Management reforms external consultants have become 'partners in governance'. They are deeply embedded through networking and lobbying in the formation of public policies. There is evidence of their pushing for their services where the quality of their product is lacking or inappropriate [4].

This manifests as incompetence of the management consultants, poor quality of their products, overconsumption of their services and levels of disruption associated with reorganisation they advise. Consulting advice is often highly standardised and lacking fit with client needs. From this perspective, consultants are viewed as 'manipulators who are seeking to influence policy makers to make more money' [4].

'Revolving door' appointments involve consultants being promoted to advisory and management roles throughout government i.e. in ministerial and civil service roles in the public sector and then moving back into private companies raising serious issues of conflict of interest [4]. There are backstage social

relationships with decision makers. A lack of accountability is combined with contracts that are far from transparent and hidden from scrutiny by 'commercial sensitivity' [3]. NHS organisations have been either unable or unwilling to engage in formal evaluation of management consulting. Kirkpatrick et al. state it would be useful to compare in-house advice with external consulting [4].

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THE lowdown

***The Lowdown* is an online weekly publication, free to use, which offers insights into the principal stories about the NHS to make the news that week.**

The Lowdown is free to view at any time but, like all health campaign publications, financial support would be gratefully received!

https://lowdownnhs.info

The Lowdown recently featured this piece, written by co-editor Paul Evans, on the government's plans to GP and community services – and the sizable kickback from already over-stretched and increasingly exhausted GPs:

Plans to boost GP and community services have ignited a fiery reaction from GPs and led to a fast climb down from NHS England. The controversy leaves key proposals for Primary Care Networks hanging in the balance.

Responding to an announcement before christmas, 70% of GP leaders said in a survey this month [1] that the targets set for the newly formed partnerships of GP practices – known as Primary Care network (PCNs), were "impossible" to achieve.

Opposition has grown rapidly since NHS England released more details of its plans for primary care. PCNs are one of the main pillars of the NHS Long Term Plan and such a strong reaction against the new scheme will be a big blow to NHS leaders as they concede the need for a re-think.

Concerns centre on a lack of money and insufficient staffing levels to support the additional activities which the new partnerships of local GPs are being asked to perform. The British Medical Association is due to enter further talks on the contract, but growing numbers of their members are already publicly rejecting it.

Dorset's 18 PCNs have opposed the draft plans while more than 1,000 GPs have signed a petition calling for the "impossible" targets to be scrapped [2].

Eight out of ten of the 447 GP partners asked by PULSE for their views, said they would not agree to signing the proposed contract.

Unrealistic plans

The new contract would require PCNs to do extra work across seven categories including reviews of all patient medication and more visits to care homes.

Many GPs feel that just don't have the capacity, but they are in a double bind though as only those GPs who sign up to the Primary Care Networks will get access to the government's £1.8bn pot of extra funding.

In an analysis of the impact of the new plans in their area [3], Berkshire, Buckinghamshire and Oxfordshire LMC estimated that each of their GP practices would end up with deficits of £100,000 a year.

In theory extra funding from the government should help to fund additional staff, but this only meets 70% of the cost and there is a considerable time burden in organising all the extra work and recruiting the staff to do it.

This LMC's report concluded that "These specifications carry an extremely high workload that would be impossible to deliver based on available workforce which exists within the health system."

Doubts amongst backers

Even supporters of the PCN concept are expressing doubts. The National Association of Primary Care (NAPC) says that draft service specifications are 'too early and too detailed", heavily implying top down interference [4]. The Kings Fund think tank reinforces the view that some fundamental issues must be addressed before PCNs can move forward: "The urgent action needed to stabilise general practice, by addressing workload and workforce issues, raises important questions around the timing, implementation and pace of these new service specifications."

Conflicting objectives

The government has made it clear that a key objective of this change is to achieve cost savings, by steering patients away from hospital towards community based care. In recent weeks GPs at all levels are offering them a reality check.

NHS digital published figures in early February [5] showing that GP practices delivered 3.8 million more appointments than last year, despite GP numbers remaining static.

The strong message being sent to NHS leaders can be paraphrased as 'don't ask any more from us, General Practice cannot work any harder'. And their demand to the Government is simple: put in the proper funding and allow us time to increase capacity and staff numbers before asking us to cope with a whole new stream of patients redirected from hospitals.

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Book Review

The Deceit Syndrome

Paul Hobday. Strand Publishing UK. 900pp. £15. ISBN 9781907340222

A novel based on the experience of a busy GP.

It is partly the tale of the fictional Rob who is fighting against seen and unseen forces to do a good job for his patients and part history of the opposition to the NHS.

The story begins in the familiar territory of a dedicated doctor struggling to do his best in difficult circumstances.

But why are the circumstances so difficult? Is it because he is unrealistic in expecting the authorities to be helpful or is there a plot to remove or to silence doctors who speak up for better services?

This book covers a lot of history and some of it helpfully told when Rob befriends an elderly campaigner who opens his eyes to the struggle to establish and maintain the NHS from its political opponents.

The history goes beyond the NHS to include Royal sympathisers with the Nazis and includes doctrinaire opposition and vested interests. The main story progresses by an analysis of current trends to a dystopian future.

The book does contain a lot of historical facts including the origins and development of neoliberal economics i.e. the rise of the movement that wishes to shrink the state and privatise everything. The narrative includes unsavoury characters involved in progressing these ideologies.

This is conspiracy theory, the author presents the facts and suggests an explanation as well as alluding to other areas of doubt such as the murder of JFK.

Dr Hobday has considerable experience of campaigning for better services including putting himself up for election as an MP. He has clearly researched well and has produced a mini encyclopaedia of forces against the NHS.

Whilst not an easy read it is a useful resource for understanding some of the forces aligned against the NHS. The novel format can allow readers to engage with characters but too many were too unpleasant to endear them to me.

This book is a clear statement that there are powerful forces that seek to replace the NHS with a for-profit service.

Eric Watts

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