DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

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Never let a crisis go to waste

'Never waste a good crisis' as it 'gives you the opportunity to do things you couldn't do before'. This is often attributed to President Obama's chief of staff in response to the 2008 financial crisis, but, according to Wikipedia, can be traced back to Machiavelli's 1513 political treatise *The Prince* which describes various evil means used by tyrants to maintain power.

In her 2007 book *The Shock Doctrine*, Naomi Klein shows how such tactics have been used frequently over the last half century to exploit both man-made and natural disasters in ways which favour free-market capitalism and already powerful corporations, with no concern for the immense harm done to the many affected communities.

Covid-19 is a worldwide crisis and comes at a crucial point in the overwhelming emergency of climate breakdown. In the UK we also face the looming upheaval of Brexit. There are opportunities for both good and bad possibilities.

In 2016, during the Brexit campaign, Sir John Major, who knows well all the individuals involved, memorably warned that the NHS would be 'as safe as a pet hamster in the care of a hungry python' if Boris Johnson, Michael Gove and Ian Duncan Smith rose to power. A pandemic such as Covid-19 presents numerous chances for those who have always intended to destroy the NHS. The well-tried tactics consist of underfunding, discrediting the resulting inadequate service, then offering the private sector as the inevitable solution. The vultures have been gathering since early in the pandemic, with columnists softening up public opinion to accept changes which would normally be rejected completely. Examples include Charles Moore, in the *Telegraph* (April 3rd) who blamed 'the inflexibility of our lumbering NHS' for the need for lockdown. Likewise, Ian Birrell (*Independent*, April 27th), in an article entitled 'the NHS can be bad for your health' blamed 'the NHS' for all the problems of PPE procurement but never mentioned the Government's major role in the issue, including the privatisation of the supply chain. The failed (and very expensive) private sector contact-tracing app is, of course, generally described as 'the NHS app'.

While the Government claims that the NHS has coped with the pandemic, it has only done so at great cost to other patients, cancelling most routine care and even many urgent treatments such as cancer surgery or chemotherapy, as well as sending thousands of often infected patients back to care homes. The return to normal is predicted to be slow, with waiting lists soon expected to reach 10 million; no doubt many patients will be encouraged to turn to the private sector and to see this as the norm. The term 'managing expectations' suggests that NHS provision is likely to become less and less comprehensive.

John Lister, in *The Lowdown* [1], draws attention to some of the very unwelcome plans which are being made under cover of Covid-19. Public engagement is to be kept to a bare minimum, a fact to be blamed on the pandemic crisis. Both primary care and out-patient clinics will be predominantly virtual, with the chances of seeing a health professional in person becoming increasingly small. Remote diagnostics will become the norm. A vet friend tells me how misleading and dangerous this can be. Moved to remote consultations by Covid-19 she was presented with a dog on a video connection. Treatment for a

common condition was started but the dog failed to improve and so was brought into the surgery to be seen. Proper examination showed widespread lymphadenopathy and the correct diagnosis of lymphoma was eventually made.

Many of these changes have long been planned by NHS England, together with (predictably) ever increasing private sector involvement, and there are also pressures to centralise diagnostic services. The implications for the NHS and for the profession are alarming and seem to take no account of the importance of the personal relationship between doctor and patient, or the benefits of continuity of care. They do not acknowledge the essential need for interaction between clinicians and diagnostic services such as pathology or radiology, or with colleagues from other clinical specialties.

There are also many implications for teaching and training. How can trainees be educated with so much remote working? Can they gain enough experience if more and more patients are seen in the private sector where trainees do not generally work? If certain effective treatments are no longer commissioned as NHS services, how can trainees learn to recognise or manage these conditions? How can medical students even learn the basics, let alone become interested in a specialty and be inspired to take it up? Will medicine even continue to be an attractive career?

In spite of all these threats, could the shock of Covid-19 crisis be used for positive change? In so many ways, it should. The public enquiry on Covid-19 – for there must be one, and with unredacted findings publicly available – should be very helpful.

The Covid crisis has shown that governments cannot just leave everything to the market, but have to take charge, must plan carefully for possible emergencies and must provide timely and sensible leadership. Unfortunately, it appears that Boris Johnson, a few days after coming to power, scrapped the Threats, Hazards, Resilience and Contingencies committee which had already been mothballed because of Brexit [2]. Countries with a more sensible approach have been far more successful than the UK and some, such as New Zealand, have effectively eliminated community transmission and life within the country has returned almost to normal although returning travellers must be quarantined.

Austerity and the resulting severe underfunding have caused serious cuts in local authority staffing and services, but this crisis has shown clearly that these well-tried local arrangements must be used promptly and need to have enough resources and local information. Outsourced and centralised services such as the very expensive and apparently chaotic 'NHS track and trace' run by Serco and others – described by the Independent SAGE as 'not fit for purpose – can never be an effective substitute.

A UK example of successful local authority action is that of Ceredigion council which started early using traditional public health measures; infections and deaths have been well below other areas [3]. NHS England's unnecessary use of centralised private-sector labs, rather than local facilities, has added greatly to the difficulties. Everybody in the UK, particularly in England, must now be aware of the fragmented, underfunded and unsatisfactory arrangements for 'social' care, mostly provided by the private sector. This is, of course, just care which people need and it cannot be separated from publicly funded NHS care. Will the enquiry find that a unified health and social care service, taxpayer-funded and free to use, is the right course of action? Let us hope so.

The economic and health inequalities shown clearly by the *Marmot Review Ten Years On* [4] have also been greatly amplified by Covid-19 [5], with increased infection and death rates exacerbated by insecure employment, poor housing and inadequate benefits – or, shockingly, the situation of 'no recourse to public funds' in the case of thousands who may have worked here for many

years (many in the NHS or the care sector) but do not yet have permanent leave to remain. An enquiry must look at all this.

The economic shock of the Covid crisis should be a chance to stimulate the green economy, with long-term benefits for the climate as well as for public health. Compared with 2019, NO_2 levels have dropped by as much as 60% in some UK cities because of reductions in vehicle traffic and this will have great health benefits. Many people have found that they can work from home and there has been a welcome and beneficial increase in active travel such as cycling, which should be continued. This is the right time for a green new deal.

The WHO manifesto for a healthy recovery from Covid-19 [6] makes interesting reading:

> **'Attempting to save money by neglecting environmental protection, emergency preparedness, health systems, and social safety nets, has proven to be a false economy – and the bill is now being paid many times over. The world cannot afford repeated disasters on the scale of COVID-19, whether they are triggered by the next pandemic, or from mounting environmental damage and climate change. Going back to "normal" is not good enough'.**

> **'The pandemic is a reminder of the intimate and delicate relationship between people and planet. Any efforts to make our world safer are doomed to fail unless they address the critical interface between people and pathogens, and the existential threat of climate change, that is making our Earth less habitable.'**

2020 is a critical and very worrying time for the NHS and for the whole UK. In this crisis there may be chances for individuals as well as organisations to influence what happens. We must take every one of them.

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Solidarity or Hypocrisy? Time to Recommit to Society

On December 1st 1942, at the height of the war with Germany, William Beveridge published his groundbreaking report entitled *Social Insurance and Allied Services*. Queues stretched from His Majesty's Stationery Office along High Holborn in London and by lunchtime all copies had been sold.

By 1948 it had changed the landscape of the country by tapping in to a profound national spirit of solidarity and a determination that future generations should never again experience the privations and injustices of the 1920s and 1930s and of the war that had just ended.

Wartime prime minister, Winston Churchill, had ignominiously, and much to his surprise, been voted out of office in the landslide general election of 1945 and a new beginning had been heralded rooted in a determination to challenge and defeat what Beveridge had described as the Five Giants of 'Want', ' Ignorance', 'Idleness', 'Squalor' and 'Disease'. For over 70 years since, the National Health service has held a special place in the affections of the British people, such that it has sometimes been described as being akin to a national religion. However, throughout this time the attitude of the Conservative party to this resilient institution has been ambiguous, with periodic efforts to dismantle it or to undermine its underpinning of social solidarity based on the pooling of risk and the principle of 'equal access for equal need free at the time of use'. The COVID epidemic of 2020 has exposed the Conservatives lack of wholehearted commitment to the NHS in a particularly vivid and cruel way, not least through the staggering numbers of deaths of health workers, put in harm's way through an ideological neglect, callousness and lies.

If the NHS is often described in glowing terms by its supporters for its ability to provide, at least most of the time, high-quality care for everybody within an ungenerous budgetary settlement when compared with similar countries, our Public Health Service can legitimately claim to have set the standard internationally from its origins in the cholera days in the slums of our Victorian towns and cities. The model of resilient and robust responses to the threats to public health from a base in the Town Hall in the 1840s was emulated around the world, not least in the countries of the British Commonwealth where its footprints are still recognisable today.

Those longstanding arrangements held sway at home until changing views on health priorities and the rise of science-based hospital medicine led to a dismantling of local public health departments and the transfer of its leadership into the NHS in 1974. After a faltering start with tragedies leading to deaths from infectious diseases in Yorkshire and Staffordshire ,in 1988, because of the poor integration between the NHS and local government, public health reinvented itself with a new vision based on multi-disciplinary and partnership working to embrace the new burden of disease posed by an ageing population and non-communicable disease. For the next 30 years it acquitted itself well including when challenged by a whole series of novel infectious disease outbreaks that included Bovine Spongeiform Encephalitis in 1986 and Swine Flu in 2009. We were fortunate that the SARS outbreak in China in 2002-3 never made it to the UK, but during that decade, partly as a result of the terrorist attack on the World Trade Centre in New York and subsequent biological warfare threats the Blair government made sure that there was a big focus on disaster preparedness. The review of our performance with Swine flu by Dame Deirdre Hine, former Chief Medical Officer for Wales concluded

that we had done well as a public health system and Secretary of State for Health, Andy Burnham, then committed a large amount of resources for equipment and stores in support of any future emergency. It was after that that the government of the day presided over everything going pear-shaped.

The combination of 10 years of austerity, the chaotic reorganisation of the NHS and of public health in England under Andrew Lansley, as Secretary of Health for Health, together with a failure to keep on top of Health Emergency Planning, as epitomised by not acting on the dire warnings that came from the Operation Cygnus exercise in 2016, and then the disastrous diversion from core business caused by the preoccupation with Brexit, means that our pathetic showing with COVID-19 was a disaster waiting to happen. It has been compounded by the absence of political leadership and statesmanship; an approach to communications that owes more to propaganda than to a commitment to honest public engagement; government advisers who were unwilling to challenge politicians and to make themselves allies of the public rather than with a Whitehall clique; the dysfunction of Public Health England and its relationships with other government bodies; the withering away of local and regional public health and the emasculation of local Directors of public Health; and above all the failure of government to be true to the needs of the public and to its committed health and social care workforce. It has been a disgrace and there must be accountability.

As with aircraft flight, so with this pandemic. The most dangerous times are on take off and on landing. Thousands have perished unnecessarily in the early weeks of the outbreak because of a lack of preparedness, of testing, tracing, isolating and treating capacity and of personal protection there has been bad faith, lies and hypocrisy. Public trust in government has been one of many casualties. Now as the first peak of the infection appears to be passing and the hope is that we are seeing light at the end of the tunnel, we are at risk of reigniting the epidemic by premature easing of the lockdown before we can be sure that robust, locally based and

led public health measures have been put in place. We are all holding our breaths.

When this is over we must make sure that, as in 1945, we come together as a country and make sure that nothing like this can ever happen again. Our democracy needs to be reformed and strengthened to make it responsive and accountable. We must strengthen our public health systems and make sure that public health as well as social care career choices can never again be seen as second rate options; and as a legacy to those patients who have died from COVID-19, at home, in care homes and in hospitals, we must create a properly funded, high-quality, locally accountable, integrated national Health and Social care service. There must also be a proper, fully transparent and independent inquiry into all that has gone wrong and which individuals must be held to account.

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Pandemics Highlight the Need for Emergency Planning

At the end of the 20th century following a decade of national major emergencies in the UK, HM Government extensively reviewed the current legislation relating to major emergency planning. Existing primary legislation was enshrined in the 1948 Civil Defence Act which since the second world war, had been supported by additional secondary legislation, but legislation was still heavily based on cold war civil defence as opposed to modern all-hazards emergency planning and was no longer fit for purpose.

Resulting from the review, new primary legislation in the form of the Civil Contingencies Act, 2004 (CCA) was enacted. This Act also included completely revised Emergency Powers Legislation – the previous update having been in 1921. It is these Emergency Powers that will have been of use in HM Government's current response to Covid-19.

The CCA defines relevant organisations as Category 1 and Category 2 Responders. It also defines the establishment of Local Resilience Forums (LRF) based on geographical areas.

One of the basic requirements of the Civil Contingencies Act 2004 (CCA) is the production and regular maintenance of a Community Risk Register (CRR). This should have the footprint of the relevant LRF area. All major hazards, both natural and man-made, are to be included and ranked according to likelihood and impact. On behalf of the Government, the Cabinet Office are also charged with producing the National Risk Register which encompasses elements of the critical national infrastructure. Many LRF risks will be similar across the country, but dependent upon geography, the level of industrialisation and hazardous sites, population, prevailing weather, air/road/rail/sea transport links and other relevant factors, individual LRF community risk registers will differ.

The CRR is produced by an LRF multi-agency risk assessment group and is a published document reviewed on a regular basis. Once recognised, each individual risk is assessed by the most relevant member organisation of the LRF. Typical membership of an LRF Risk Assessment Group will be made up of Category 1 and Category 2 Responders including local authorities, emergency services, all relevant parts of the NHS, Maritime & Coastguard Agency, Environment Agency, Public Health England, Public Transport providers, Airports, Utility Companies, Telecommunications Providers, Network Rail, Highways England and others, with each represented by emergency planning staff. Once risk assessed, individual risks or similar risks may form the basis of emergency plans used to deal with the pre-planning, exercising, response and recovery phases should a particular risk result in a major emergency as is the case with Covid-19.

All levels of Risk Register in every part of the country, both national and community, have since 2004 had 'Influenza Pandemic' as a global terminology for acute respiratory infections, identified as the 'number one risk' based on likelihood and impact.

Category 1 Responders produce emergency plans for their own organisation to follow, and will work together and produce LRF plans where required.

The Director of Public Health role was returned to upper tier local authorities from the NHS in 2013, having been originally created there in 1847

when Dr William Henry Duncan was appointed as Medical Officer of Health in Liverpool. Since 2013 the Public Health Grant received by many upper tier local authorities, as a result of austerity measures, has been reduced in real terms by over a quarter and many DPHs are now line managed by Directors of Social Services and do not sit on Town Hall leadership teams. This has lead to smaller staffing levels at such a time as now, when staffing levels should have been as large as possible.

The statutory and non-statutory services delivered by local authorities impacted by Covid-19 will be many and varied. In this current pandemic, the number of cases and associated deaths is of course much, much greater that the H1N1 of 2009 which was about 17,000 deaths worldwide, and the pressures on the local authorities will be far greater at a time when chronic underfunding has significantly reduced the staffing and capacity within all departments. These services will include:

- Public Health
- Social Services – all aspect of work including domiciliary care and day centres, mental health, hospital discharges
- Environmental Health
- Coronial Services
- Cemeteries and Crematoria
- Registration Services
- Education
- Human Resources – including call centres
- Information technology
- Facilities Management – building maintenance, supply and provision of PPE for staff
- Coordination of voluntary effort and community resilience
- Mayor's office, Chief Executives, Emergency Planning, Finance, Communications etc.

Many believe that the response to the Covid-19 pandemic would have been better managed by including a regional strategic and tactical level rather than solely by a national strategic management model. Local authority Environmental Health and Trading Standards departments are by necessity skilled at contact tracing - Food Safety, Port Health, meat inspections, Healthy Homes, HMO Licensing, Health and Safety Units all work utilising well practised testing and tracing mechanisms and as such may appear in many Pandemic Plans. The NHS Contact Tracing System recently announced, is being provided mainly by the private sector when there is so much well practiced testing and tracing that could be available through the DPH and his or her local authority colleagues – albeit with austerity staffing numbers. Many cities and city regions also now have a Mayor with the strategic responsibilities, leadership and funding that goes with the post.

What has changed greatly since the H1N1 pandemic is the importance and use of information technology and social networking platforms by the public, local authorities and central government. Since 2009 there has been a massive shift in the ability of information to be disseminated to and between the public and the ability of council services to be provided on-line or over the phone, and by a huge increase in home working for staff. Facebook and Twitter pages managed by the local authority are being widely used to disseminate information and best practice, point to other service providers and their information, recruit volunteers to assist and encourage community resilience, amongst many other things such as grants and support for small businesses and voluntary groups.

What is now clear is that Emergency Planning, too often seen as the Cinderella service within many organisations, is a core statutory service that is central to the management of major emergencies – whatever the cause.

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The Value of Migrants

A few weeks ago, on 21st May, the UK Government scrapped the Immigration Health Surcharge (IHS) for migrant NHS staff and care workers – a fee which migrant workers must pay in order to access the NHS, in addition to ever-increasing Tier 2 work visa fees [1].

This exemption was sorely needed and long fought for, particularly since the government revealed its plans to increase the IHS from £400 to £624 per year from October 2020. In light of Covid-19, this became a pressing concern as migrant NHS workers who have selflessly worked to protect the British public throughout this pandemic would continue to be charged such an extortionate fee to access the service they themselves provide.

Yet, despite welcome news of the exemption, the government's decision to scrap the IHS for NHS workers has been met with justifiable scrutiny and criticism. One such criticism voiced by campaigners and the general public was that the government's initial announcement awarded this exemption to doctors and nurses only, neglecting all other NHS staff and professionals in the care sector.

Initially, the Government hoped that by exempting doctors, nurses and paramedics from the Immigration Surcharge, they were paying their respects to frontline hospital and health staff. Yet this demonstrates a clear failure to appreciate or even to recognise the sacrifice of all other NHS and care workers, who ensure that the wheels of the NHS function properly and are essentially the backbone of the health service. From porters, to care workers who are dedicated to supporting and assisting the most vulnerable residents, the government's disregard of these workers hints at a pervasive attitude which looks upon vital but lower paid migrants as unworthy.

Thankfully, as a result of mounting pressure, the government extended this exemption to all NHS and care workers – including those previously overlooked low-paid workers – confirming that they would no longer be subject to paying the health surcharge. Covid-19 has no doubt increased a small sea change in attitudes – no longer viewing these individuals as statistical income but essential workers who are providing a crucial job in the health service overall. Yet this demeaning attitude towards low-paid workers regrettably remains within the UK's immigration system. And unfortunately, concerns regarding the IHS exemption do not end here.

At the end of May, the Prime Minister was confronted with questions regarding why the surcharge is still in place for NHS and care workers, 4 weeks after his May 21st announcement [2] that it would no longer apply to these individuals. Johnson responded that he is 'working to drop the fee', which only served to confirm accusations that the workers in question are still being charged. He insisted that they would be issued a refund. However, at present, there is no information regarding how a refund may be claimed or how long it will take for the exemption to come into effect.

One doctor highlighted how he has had to pay £6,000 in IHS fees so far to cover himself, along with his wife and four children [3]. The Home Secretary is therefore now being asked to ensure that not only NHS and care staff are exempt from paying the migrant surcharge but that their spouses and dependents are too. In June, the *British Medical Journal*, Royal College of Physicians, Royal College of Nursing and Unison wrote to the Prime Minister, asking for the surcharge exemption to be extended to spouses and dependants, along with a recommendation

that the charges be exempt permanently.

What's more, what the government's current IHS exemption fails to address is the invaluable work and dedication of all other migrant workers who have similarly helped to keep the country running at such an unprecedented time. Those who work in other industries yet still provide key services – such as cleaners, delivery drivers, teachers and public transport workers to name just a few – all continue to be subjected to the rapidly rising surcharge. Many low-paid migrant workers in the UK struggle to fund the IHS and this is only set to be exacerbated with the rise of the fee in October. In addition to this, the introduction of the new points-based system due to come into force in January 2021 is set to have a catastrophic impact on many industries – including the NHS. The annual salary threshold will be lowered to £25,600 from £30,000 yet this still fails to account for lower paid workers, including those mentioned previously, many of whom earn well below the £25,600 threshold. Now more than ever, the Government ought to be encouraging and welcoming these vital workers, yet many will be deterred as a result of hiking visa and health surcharge fees.

What Must Change

A lot of the government's approaches up until this point could be exemplified by comments such as "It's the National Health Service, not the International Health Service" – said by Health Secretary, Matt Hancock [4]. This positions migrant key workers as spongers, unnecessary and a drain on the system yet the figures show we need them more than ever. If we are to take any lessons from the tragedy of Covid-19, valuing all migrants – and therefore scrapping the surcharge for all vital workers, not just health and care staff – would be one step in the right direction.

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Forensic Threat?

The role of forensic examiner, often glorified in the media and fiction, is also at risk from privatisation. The Chief Examiner for the Faculty of Forensic & Legal Medicine of the Royal College of Physicians gives her personal view.

In 1995 I became a police surgeon, then a forensic medical examiner and now a forensic physician. It is not only the name which has changed, but how I do the job has moved from a very forensic process, largely concerned with the criminal justice system, to a much more holistic, health related consultation.

When I started, forensic medicine fell between the two stools of health and criminal justice: then, as now, the service was under-resourced and the medical complexity of the role largely unrecognised by health. The huge impact sexual violence has on the physical and mental health of victims appeared to be ignored by health services and the medical and mental health needs of those in police custody of very little account.

It was a long-forgotten television documentary of Thames Valley Police grilling a female complainant of rape, as though she were a liar, that ignited my interest initially and the reaction to that programme also encouraged police authorities to change the way they dealt with rape victims. I had also become aware of how much abuse of children, physical, emotional and sexual, happens behind closed doors. Once my children were a little older, I decided I could combine part-time work in general practice with the care of sexual assault complainants – adults and children – and of detainees in police custody: Merseyside Police insisted that, if I were to work with the victims of sexual violence, in the interests of balance and objectivity, I should also provide medical care to the alleged perpetrators and others arrested by the police. Although that resulted in a heavier workload and more interrupted sleep, I am grateful for the opportunity it gave me to see both sides of the issue and it was always good to be greeted in the custody suite at 2 am with "Hiya Doc" from one of my GP patients. I therefore also provided medical care for detainees in police custody until 2008 in addition to the forensic examination of complainants of sexual violence, which I still do. In 2008, after 12 years of struggle to secure funding and accommodation, we opened Safe Place Merseyside, Sexual Assault Centre (SARC), based in Liverpool, and I was its clinical lead until 2015.

In the early days, I could finish morning surgery and visits, fit in a child sexual abuse examination with a paediatrician at the local police suite over lunchtime and return in time for evening surgery.

These days are long gone but the need for care of the highest standard for complainants of sexual assault, who are seen at their most vulnerable, and for those in police custody remains. The high levels of mental health needs and drug and alcohol issues encountered in custody suites is a constant, then and now; the more recent provision of mental health liaison and drug and alcohol dependence services in custody suites is a very welcome support. Now all children in Merseyside up to the age of 16 (18 if some disability is present) who require forensic examination in connection with child sexual abuse are seen in the Rainbow Centre, Alder Hey Children's Hospital where they are seen by a paediatrician and a forensic physician as part of a holistic safeguarding service.

When I started in 1995, all of this work was

undertaken by doctors, often general practitioners, around their other work commitments, with governance and ongoing training and professional development overseen by more senior colleagues. We were all retained and paid by police authorities but not employed by them as our role was as independent medico-legal professionals not police employees: there might be need to hold police to account for injuries sustained by detainees during arrest or record injuries on complainants which cast doubt on their account of events. The objectivity of forensic medical work remains important in the health and criminal justice systems. Forensic physicians in Merseyside remain on an honorary contract, with no paid annual, study, maternity or sick leave, being on call for £7.50/hr and item of service payments for examinations set in 2008.

Since 2006, much of the work has been outsourced to private providers, such as G4S, Mitie and Mountain Healthcare who employ nurses and paramedics to perform most forensic medical examinations in custody, with possibly a doctor overseeing from a distance by phone. The presence of a healthcare professional in a custody suite, rather than having to rely on summoning an 'on call' doctor from home or in the middle of evening surgery is very valuable: working as a team, which is how healthcare has traditionally worked would be ideal. Unfortunately, when other healthcare professionals were introduced into this work, it never seemed to result in both-and, always either-or. Many sexual assault services are nurse-led services with nurses who are not paediatrically trained examining under 18s on a regular basis. This is despite guidelines on best practice that under 18-year olds should be examined by doctors with paediatric competencies. NHSE, Commissioners of services and CQC inspections appear to ignore FFLM guidelines about quality standards when services are commissioned, despite strong representations by the FFLM.

The Crown Prosecution Service appears to accept a minimal quality of Professional Witness evidence in Court, where the examining healthcare

professional feels unable to give an opinion on the range of possible causes of an injury and the expert opinion is given by a doctor who has never seen the complainant or, in some cases, communicated with the healthcare professional who conducted the original examination.

This is a complex area of medicine addressing the needs of often very vulnerable individuals, both in terms of their mental health and social circumstances and truly "the job is much more than the swab".

The Faculty of Forensic & Legal Medicine (FFLM) of the Royal College of Physicians of London is one of the faculties of the RCP. The inaugural meeting took place on 13 April 2006. The FFLM's main aim is to develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity. The FFLM is in the process of applying for Specialty Status which should help to make it much more possible to have a career as a forensic physician. Much more information about the FFLM is found at www.fflm.ac.uk

While only doctors can sit the membership examination, the licentiate, which is a competency examination, is open to all healthcare professionals who do forensic work. The faculty also offers the Diploma of Legal Medicine (DLM) to all professionals involved in medico-legal work. The qualification of MFFLM, allows recognition as an expert witness by the courts, and is the appropriate qualification for any doctor intending

to continue working in forensic medicine.

The LFFLM denotes a healthcare professional who is competent to conduct forensic examinations independently; it is recommended that any nurse examining children under the age of 18 is paediatrically trained but those without that training can assist a physician or paediatrician in the recording of injury and the taking of swabs. The LFFLM qualification may also be of interest to experienced paediatricians or sexual health doctors who have already membership of their professional bodies, as a confirmation of their forensic competence.

My role as Chief Examiner is to ensure that the examinations are set at an appropriate standard and to support the examiners and Question Leads who give generously of their time in order to create, standard set and mark examination questions.

What are my concerns for the future?

I worry that, with the commissioning of private providers, the provision of a truly holistic service takes second place to costing of a service which will address the minimum specification.

I am concerned that the importance of a broad range of forensic and medical competencies and experience of healthcare professionals, particularly when examining children and involving mental health assessments, is undervalued by commissioners.

In some nurse led services relating to sexual offences, nurses who are excellent practitioners and passionate about providing care, are being asked to work outside the competencies which their training and development allow.

I regret that an opportunity to work as a healthcare team, particularly in custody medicine, has been lost and that fewer skilled doctors are given the opportunity to choose forensic medicine as a career.

I worry that there is an increased risk of death in custody [1].

I worry that the quality of medical evidence, particularly in the forensic assessment of injuries and their possible causation, is diminished if the professional who examined the complainant is unable to give such opinion. As a forensic physician, I am rarely now asked to give evidence in court in person, even in those cases where medical evidence is relevant, and so an opportunity is lost to explain to a jury the significance of particular injuries or the neutrality of the absence of injury in a rape complainant or child where sexual abuse is alleged.

Despite these concerns, I am not yet ready to hang up my forensic medical boots.

Reference

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Forensic Science privatisation

The demise of the Forensic Science Service (FSS) in 2012, supposedly on 'efficiency' grounds (sound familiar?) was followed by a chorus of concern as privatised and in-house services sprang up to replace it. The increase in privatisation in forensic science services has given many grounds to believe the risk of miscarriages of justice has increased alarmingly.

Gagged and Bound: Why doctors don't speak up

On 30 December 2019, Dr Li who worked in Wuhan general hospital sent a message to seven fellow doctors in a chat group warning them to wear protective clothing to avoid infection as he had noticed a cluster of seven cases of SARS-like pneumonia.

He got into trouble with the authorities. He was reprimanded because he had 'severely disturbed the social order' but did not lose his job. Doctors are a precious commodity.

On 30 March in England, doctors spoke out publicly about widespread shortages of personal protective equipment which they feared could put their lives at risk from acquired coronavirus. It was soon reported that staff were being gagged. Some were warned they could face disciplinary action if they engaged in 'inappropriate social media commentary'. Could these doctors lose their jobs or will they be treated as precious commodities?

History of NHS Disciplinary Procedures

NHS disciplinary procedures have been unsatisfactory for decades. In 2004, the Committee of Public Accounts (CPA) held an inquiry [1] into the management of suspensions of clinical staff in NHS hospitals after a damning report from the National Audit Office (NAO)[2], itself instigated by the CPA in 1995.

The NAO report showed that over a 15 month period from April 2001, 1000 clinical staff had been suspended for more than a month. This included 200 doctors of whom only 40% returned to work. The length of exclusion averaged 47 weeks for doctors with a handful excluded for as long as 4 years! Among consultants, a significantly higher proportion of those from an ethnic minority suffered exclusion.

The NAO made recommendations based on the savings which would accrue but noted with remarkable empathy that "In addition to the financial costs, the human cost to excluded clinicians and their families is high, with many excluded clinicians experiencing reduced self esteem and depression". Pre-empting Sir Robert Francis, the NAO recommended the promotion of an open and fair culture which would identify systemic weakness rather than focus on the shortcomings of individuals.

Maintaining High Professional Standards [MHPS] *in the Modern NHS: A framework for the initial handling of concerns about doctors and dentists in the NHS* followed in December 2003 [3].

Incorporating NAO recommendations it laid emphasis on:

- Consultation with the National Clinical Assessment Authority (NCAA) at an early stage when suspension was being contemplated.
- Considering alternatives to exclusion which should be regarded as a last resort.
- Time limits on exclusions: with regular review and a six month limit.
- Responsibility at the top lay with the chief executive and non-executive board member.

The guidance was finalised in 2005 with a new contract of employment agreed with the BMA. Regrettably, it abolished doctors' right of appeal to the Secretary of State with the entire procedure remaining internal to the employing organisation. It also abolished Special Professional Panels ("the three wise men").

The NCAA was a special health authority set up in 2001 by CMO Liam Donaldson to advise

healthcare organisations on the most appropriate actions to be taken over concerns about the practice of a doctor and aimed at reducing the need to use disciplinary procedures to resolve problems. Although advisory, it was hoped that it would influence Trusts and report on trends, patterns and concerns and in its early years it demonstrated a reduction in the number of cases leading to exclusion. In 2005 it was renamed National Clinical Assessment Service (NCAS). It was no longer an 'Authority'.

In 2013, NCAS reported that over a 11 year period 6,179 doctors were referred to it (5 per 1,000 doctors per year) [4]. It is noteworthy that the study was set up to identify 'risk groups of doctors' and not whether the actions of the employing authorities were reasonable or appropriate or in keeping with MHPS guidance. Doctors in the late stages of their career were reported as being more likely to be referred than those at an early stage.

Older doctors are of course the group most likely to speak out or complain but the *Independent* newspaper reported this as 'Older doctors are six times as likely to pose a risk to patients'. It was also reported that doctors 'who gained their first medical qualification outside the UK' were more than twice as likely to be referred compared with UK-qualified doctors. The term ethnic minority doctors were not applied to this group. It was deliberate avoidance of a problem to which NAO drew attention 10 years earlier.

NCAS became increasingly irrelevant, with the High Court eventually confirming in 2014 that there was no obligation for employing authorities to accept its advice. It is now the Practitioner Performance Advice Service (PPA), a part of NHS Resolution/ NHS Litigation Authority.

Following the Mid-Staffordshire Public Inquiry by Sir Robert Francis "Freedom to Speak Up" (FTSU) guidance was produced by NHSE in 2016 [5]. The unwillingness of staff to make formal complaints was attributed to fear of retaliation. Victimisation may take the form of bullying and harassment from peers and management or disciplinary action seemingly unrelated to the event. Disciplinary procedures are widely seen as inconsistent and unfair and likely to be followed by dismissal. This a key factor preventing doctors from speaking out.

As with the NAO recommendations, FTSU recommended a change in culture rather than in legislation. Whistleblowing protection is afforded by law but is in itself a blunt instrument. Whistleblowers are theoretically protected by the Public Interest Disclosure Act but only after they have suffered detriment. Another confounding factor is that the legal position of a doctor who 'speaks up' is unclear. Remarks and observations or refusals shared during discussions in relation to service transformation or in support of a colleague may not be a 'disclosure' as defined in whistleblowing legislation.

Although current MHPS and FTSU guidance documents are comprehensive, in practice their implementation is far removed from the spirit of the recommendations. Creating confidence in disciplinary procedures is of paramount importance in supporting an open and fair culture.

The Problems

1. MHPS guidance is not mandatory

It was agreed with Monitor that it should be issued to NHS Foundation Trusts as advice. While Trust disciplinary procedures are expected to be consistent with the guidance, compliance and interpretation may vary. Discretionary variations such as the right to legal representation have been established through the courts [6].

2. Basic management principles are not followed

Disciplinary action is often taken on the basis of individual shortcomings despite evidence of systemic failures. A problem relating to service provision or dysfunctional team working warrants early resolution rather than exclusion on tenuous grounds such as 'a

breakdown in working relationships'.

3. Exclusion is not the last resort and the 'suspension culture' persists

Alternatives to exclusion are not actively explored even when patient safety is not at risk. The risk of a doctor being 'likely to interfere with or otherwise hinder investigations' as a catch-all slur must be justified.

4. The terms of exclusion are punitive

Being barred from entering the workplace has an enormous psychological impact. It also leads to impairment of professional skills and expertise and impedes professional development often to a serious degree. It also interferes with their ability to gather data in their defence. It is not uncommon to find managers adding new allegations and continually shifting goal posts - further undermining their defence strategy.

5. Exclusions are not time bound

The recommended key stage reviews are rubberstamped through. The abolition of a doctor's right of appeal to the Secretary of State was made because it had been argued that this clause resulted in costly and lengthy appeals but it has not had the desired effect – possibly because there was no objective evidence to support that argument in the first place.

6. Expertise within Trusts is poor

Before the establishment of Trusts some expertise resided with Regional Directors but this expertise has not been replaced. With the virtual elimination of input from NCAS there is no oversight or influence over the proceedings by any organisation outside the Trust.

7. There is no external scrutiny of procedures

All procedures including appeals remain internal to the employing organisation. The recommended membership of the appeal panel should include experts from outside the Trust (Originally an 'independent member trained in legal aspects of appeals from an approved pool' was recommended as chairman). The appeal process is not seen as being objective and considered a rubber-stamping exercise.

External scrutiny is only afforded through an appeal to an Employment Tribunal (ET). This can take an unacceptably long time – a period of years rather than months – during which permanent loss of career and penury are not uncommon.

8. Lack of individual responsibility

Root cause analysis may lead one to blame poor attitudes at government level but ET judgements reveal poor management decisions at many levels within the Trust. Waves of disruption and enforced changes and mergers inevitably lead to challenges by doctors. Managers have to respond to pressures from above and targets have to be met and dissent is not welcome but has to be managed. Managers are paid for managerial responsibility so they should be individually liable.

9. BMA support is of variable quality

There is an obvious conflict of interest in that the BMA is likely to represent the victim

as well as the medical managers. It is also likely that financial considerations influence the level of support they are willing to provide. They are prone to withdrawing support for no clearly comprehensible reason. Decisions are allegedly based on 51% likelihood of a successful outcome. A negotiated settlement is usually encouraged in preference to an ET appeal. This may save time and money but 'fairness' is not an overriding consideration and victims are often left dissatisfied.

10. BAME doctors are disproportionately affected

Sex discrimination can be subtle and difficult to prove but undoubtedly occurs [7].

[Different regulations may apply to non-medical staff and doctors in training and GPs and in the devolved nations.]

Proposals for change

In March 2018, in response to widespread concern NHS Improvement (NHSI) produced "A Just Culture Guide" [8]. The one page guide is ridiculously simple and takes the form of a series of questions to clarify whether there is truly something specific about the individual or whether there is a wider issue. This is basic decision-making methodology. Its objectivity should help avoid formal action and reduce disproportionate disciplinary action against black and ethnic minority staff.

In May 2019 an awareness of the tragic consequences of disciplinary procedures led to further guidance distributed to all Trusts with a covering letter from Baroness Dido Harding Chair NHSI [9].

In July 2019 "Fair Experience for All: closing the ethnicity gap in rates of disciplinary action cross the NHS workforce (July 2019 from Workforce race Equality Standard)" aired proposals for overcoming problems relating to ethnicity [10].

These are valuable practical documents but the lack of progress over these many years is evidence that some degree of enforcement is required.

1. A Trust based independent Board to oversee disciplinary procedures in real time.

A group of 3-4 doctors of should be elected by the Trust medical faculty. Those in managerial positions and union representatives would be excluded. Such a Board would bring in multiple perspectives and a general perception that procedures are objective rather than dictated by management. It is in keeping with a proposal made in 'Fair Experience for All' [10].

This board should be consulted:

i) Before exclusion to ensure that

- Systemic failures have been identified and resolved.
- Management issues such as dysfunctional team working which may have had an impact on the practitioner's actions are taken into account.
- Alternatives to exclusion have been explored and that exclusion is a last resort.
- The terms of exclusion are appropriate to the charge and circumstances and that return to work in a limited capacity or in a non-clinical role has been explored.

ii) At key stages to ensure that

- Case investigators are fully trained and can demonstrate there is no conflict of interest.
- The process is time bound as detailed in the procedure.
- There is fair access to the work place and work records in order to prepare their defence. It should include access to patient records and internal e-mails so that court summons, patient complaints etc can be attended to without delay.
- Return to clinical work is facilitated by a robust programme of continuing professional development, clinical audit, appraisals and revalidation.
- The impact on clinical services is minimised.

2. Scrutiny of outcomes and appeals by independent experts from outside the Trust

This is permitted in the Maintaining High Professional Standards (MHPS) guidance) but not enthusiastically applied

3. A central record of all suspensions

This could be with NHSI or NHS resolution and should be mandatory. Audited reports should be published.

4. Limiting clauses on negotiated outcomes should be banned

Negotiated outcomes bound by limiting clauses prevent disclosure of settlements and mask accountability.

5. Individual decision makers should be held accountable

Where individuals have been identified as acting improperly in court or at appeal, they should be held accountable. In a 2011 ET judgement the Trust and three individuals (head of department, medical director and HR director) were made jointly liable [7] creating a precedence.

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Publish and be damned? Freedom to Speak Up (FTSU) in the NHS

A paper jointly presented by Doctors for NHS, WhistleblowersUK and ourNHSourconcern

Following the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) Sir Robert Francis had made a number of recommendations pertaining to the culture of the NHS [1].

A further independent review in 2015 [2] concluded that there was a serious issue within the NHS in the way whistleblowers were treated. Two factors stood out from the evidence: fear of the repercussions that speaking up would have for the individual and for their career; and the futility of raising a concern because nothing would be done about it. The report observed that there was a real need for a culture in which concern raised by staff were taken seriously, investigated and addressed by appropriate corrective measures. Above all, behaviour by anyone which was designed to bully staff into silence, or to subject them to retribution for speaking up must not be tolerated.

Following the Francis Report in 2015, NHSE produced guidance to Trusts on FTSU in 2016 and again in 2019 [3-5].

The NHS Staff Survey in 2019 [6] average results revealed 40.9% thought that communication between senior management and staff was effective, 32.4 % stated that senior managers acted on staff feedback, but 13.1% reported being bullied by managers.

As recently as this year, staff were gagged, forbidden or bullied from speaking up [7].

The above demonstrates that the NHS has not established the type of culture recommended in 2015. This paper states the current structures in place to support FTSU at local and national levels, what the problems are and present the solutions.

Current structure and responsibilities

Local level

1. All executive directors have responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement.

2(a) Chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.

(b) Chief executive and the chair role-model high standards of conduct around FTSU and are responsible for ensuring the appropriate annual report is presented.

3 (a) The non-executive lead for FTSU is responsible for role-modelling high standards around FTSU.

(b) The non-executive lead for FTSU should challenge the executive board to reflect on whether they could do more to create a healthy and effective speaking up culture.

4. Director of Human resources also has a responsibility to ensure the above.

5. The appointed FTSU Guardian is the designated person to ensure all necessary resources are provided, process all complaints, to prepare annual reports and to provide appropriate assistance to the complainant.

6. Confidentiality – Any person raising a concern

must have the right to be anonymous.

National structure

1. The National Guardian sets standards, receives reports, provides training for local guardians in addition to accepting appeals.

2. Structure for whistleblowers is the same but a 'protected disclosure' is covered by a specific law. The Francis Report noted that the legal position of whistleblowers was not clear.

Processes available to staff to raise concerns

Step one – contact line manager, lead clinician: if not satisfied

Step two – Approach FTSU Guardian: if not satisfied

Step three – Contact CEO, medical director, nursing director or finally, non-executive director

Step four – National Guardian

What are the problems?

1. All the people concerned in the process described above are in the payroll of the trust and many of whom also hold some managerial appointment. As noted already, staff work in an environment of fear and this makes most members of staff reluctant to approach them or the local Guardian. In the event of a minor event or when an individual is raising a concern on behalf of a team or department, one may well approach any of these people.

2. There is no assurance that the identity of the individual will be kept secret. The Guardian normally takes the concern to the CEO and the matter rests there. No one is informed if any action has been taken; the usual reason is that the complainant was anonymous. This should not stop the Guardian, who knows the identity, to inform the individual privately.

3. Most of the staff have no other place to complain to. The National Guardian usually refers to the trust, thereby making the process just as bad. It is therefore not possible to know how many people do not express their concerns because of fear of retribution or the feeling that nothing will change. One can guess this to be significant as shown in the National Staff Survey [6].

4. The culture in most trusts is one of fear, failure to value staff and lack of transparency. Suffice it to say that since the Francis Report the culture has not improved.

5. The legal position of whistleblowers remains unclear.

6. Those individuals who have experienced retribution and subsequently found to be innocent often end up with permanent loss of career and other problems. The time it takes to resolve these issues is not acceptable.

7. The local disciplinary processes to which many of the whistleblowers are subjected to are not fair in that most of the judging panel and the prosecution are from the same trust, a system of justice that can hardly be supported.

Solutions and discussion

1(a) Independent Guardian should be available as an alternative to the current structure. It is acknowledged that some concerns may be dubious, but this can be ascertained through seeking more information. In the event of an individual wishing to remain anonymous, this alternative service could still approach the relevant trust for an explanation; in so doing it will be important to ensure that the

report to the trust is couched in a way that may not identify the individual.

1(b) Even if this independent guardian is unable to take up the case it will still be able to give advice and refer to appropriate associations.

1(c) It is important to set up a system that will encourage staff to speak up without fear of being revealed. The record held will be helpful to know which trusts are involved, the natures of concerns and the staff status. Such anonymised information will be helpful to pass to interested organisations and NHSI and National Guardian.

1(d) The independent body should not be on the payroll of any NHS structure, central or otherwise. Ideally, this should be supported by voluntary bodies concerned with NHS matters, working as a collaborative activity.

2(a) The legal position should be clarified by a change in law. This change should entitle courts to impose fines on the trust or an individual identified as the culprit or in the absence of these, the CEO. This change may not be as effective in changing the culture because the fine will not be paid by any member of senior management but by the taxpayer. Making it a criminal offence may do so, particularly if the CEO is held to be responsible although it is unlikely that legislators will agree with this.

2(b) Whistleblowers should be protected from any disciplinary action but only if the nature of the concern is justifiable.

2(c) NHS institutions and trusts must be banned from making 'secrecy agreements' or gagging clauses under any circumstance.

3. Change of culture is urgently required. Changing the law as stated above is unlikely to make any significant improvement. The only other alternative will be to empower staff; this can be done by changing the law to enable staff to elect its own executive board every three years. A separate referenced document on this subject is available.

In conclusion, at the risk of stating the obvious, no improvement in Freedom to Speak Up will happen until there is a change in culture.

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How and why have we so misbegotten our NHS staff?

An analysis of the culture of the NHS and its social and motivational psychology

At the time of writing (May 2020) much of the world is anxiously stymied by Covid-19: our assumptions of contemporary living simultaneously and shockingly unravelled and impassed.

In the UK, at the centre of our crucial battle of Humans *v* Aliens, our NHS is now lionised and eulogised in heroic terms. Like religious icons or Soviet State art, its practitioners have become our saviours and our martyrs. This warm mist of adoration has – until it passes – obscured a serious problem that has grown increasingly erosive of our NHS for several years: the destabilising demoralisation of much of our workforce.

This Covid-crisis has, as emergencies do, galvanised a new cooperative and colleagueial motivation in many of our professionals as they are – for now – again trusted to do their best to stem the alien tide. But as our enduring serious problems are temporarily out of sight we should beware: they remain, like perilous rocks, just beneath the water's surface. While we currently have the respite of dramatic distraction, we certainly do not have reprieve or resolution of our systemic troubles. They will surely return.

So what are these rocks-beneath-the-surface that can sink this enormous, and enormously important, social vessel – our NHS? It is crucial that we ask this question in anticipation (hopefully) of a post-Covid national recovery as we will otherwise then return an exhausted, even more vulnerable, NHS to these enduring and gathering imperilments.

The underlying problem

Our healthcare headlines and news items in recent pre-Covid times were frequently about a service labouring under a regime riven by accusations and disputes about finances, territory and responsibility. While still, often, providing satisfactory technology-dependent treatments well enough, the services for many years have been clearly struggling and malfunctioning in less hi-tech areas, particularly general practice, mental health and community services. This is reflected in a wide range of statistical indicators both for staff and patients in these domains. Staffing levels are often shown to be unsafe and unsustainable due to poor recruitment, sickness, intra-institutional litigation, career abandonment and earliest retirement. Remaining staff then struggle even more to provide even essential access and services to patients. Any more nuanced personal continuity of care becomes impossible, further demoralising and endangering depleted, wearied staff and vulnerable patients.

Arguments and quasi-explanations are often translated into discourses about money. The services' spokespersons say, 'we don't have enough', and the government says 'you do have enough, but you're not using it efficiently: you need better management'. Variations of this exchange have been going on for 30 years, since the neoliberal revolution.

The nature and evolution of this philosophy – neoliberalism – is worth clarifying, as that will help us understand our current predicament. Neoliberal reform of the NHS began in the heyday

of the Thatcher government, which said effectively: 'Welfare services are slack, inefficient and have too much unmanaged variation. This is what happens if professionals make their own decisions and define their own tasks. We need then to replace autonomous vocation by commissioned and expertly designed corporation; and those corporations need then to be motivated, tested, challenged and stretched by the rigours of a competitive market.'

Neoliberalism tends to view human activity and motivation in a machine-like way: humans can, therefore, be designed, tweaked and boosted to provide ever-improved performance or 'output' to meet the user's requirements. This approach is akin to a carpenter who procures his material and then designs, cuts, shapes and joins it precisely to his requirements. The wood itself is now a lifeless commodity whose only use is the carpenter's plans.

Let us contrast this to the more organic, holistic activities of a gardener. Here we may have a vision or plan, but we cannot precisely command and manufacture these. We must instead understand the viability and growth requirements of the various plants and their complex relationships with other life-forms, their eco-systems. Then we must plant, protect, tend and nourish with care and deliberation.

Our pre-neoliberal NHS had these organic, holistic principles of better human sense guiding its management although this was never (as far as I know) referred to explicitly. The service was certainly not perfect, but in the main it had high work satisfaction, happily convivial work relationships and enduring robustness and sustainability. The tragedy of our neoliberal reforms is that rather than building on these organic, holistic, time-honoured tenets of human groups, they demolish them in the spurious belief that a commercial-industrial type model would work much better. In a way these reforms have been more like a revolution; and revolutions, like wars, almost always yield something very different to what was planned.

To establish decisive control these neoliberal reforms have invested heavily in three main institutional strategies. They are:

- *The 4Cs:* competition, commissioning, commercialisation and commodification – a marketised system.
- *REMIC:* remote management, inspection and compliance – a surveillant and policed system.
- *Gigantism:* scaling up and standardising wherever possible – a system of industrial capacity and efficiency.

Together these three reforming vanguards have certainly revolutionised our NHS working culture from one of convivial cooperation to that of industrially commanded compliance: from family to factory. This radical transition may make sense in the abstracted spaces of government and management committees, but it makes much less sense at the practitioner and patient level – for here our actions and experiences are very much the products of the bonds, meanings, trust and resonance that develop from shared personal access and knowledge. Underlying our technically designated tasks, these are what confer human gratification for doctor and patient alike. For any of this to happen, the practitioner must be assured of headspace and heartspace but, tragically, our three revolutionary vanguards have been developed to short-circuit and exclude such invaluable human vagary. The revolutionary rhetoric is usually pitched around mooted (and mistaken) gains in efficiency, safety and value-for-money.

And what is the reality, now, of our neoliberally industrialised NHS? The evidence, from many sources, is that, most often, the 4Cs, REMIC and Gigantism have fragmented, dispirited and demotivated the previously more fraternal vast NHS professional network. By introducing a competitively siloed mentality, unprecedently complex bureaucracy and procedures, and

then attempting to control all thought and activity through micromanaged surveillance and compliance regimes, our service has become, all too often, less safe, humane or efficient. After all, how well can an abandoned, depleted workforce achieve any of these things? And even if the staff remain in post how well can they work if they feel unfulfilled, devalued, mistrustful, mistrusted and without fulfilled fraternal bonds – both with other workers, and with their patients?

The neoliberal agenda – with its control-levers of contracts, goals and targets, compliance instructions, rewards and penalties, sticks and carrots – has abrogated a central human principle of how we may best care with and for one another. Good welfare comes little from money, institutional fealty or compliance; it comes far more from finding and tending shared experience, meaning and thus relationship. Welfare practitioners motivated and gratified in this way are hardly ever 'poor performers'; conversely if practitioners are unhappily frustrated in these ways they are most unlikely to proffer the kind care we, they, or anyone would want.

This is what, in our zeal to 'modernise', we have so heedlessly sacrificed.

The present

There is, currently, a rising swell of frustrated contention among practitioners alleging (with copious and substantial evidence) numerous examples of mismanagement by licensing, employing or disciplining authorities. At their most 'benign' such allegations may be about out-of-touch incompetence; the rest sound shaded with the opaquely dissembled, the corrupt and the malfeasant. Constructive dismissals, gagging orders, officious skewering by small print regulations, procedural obfuscation, traducement of whistle-blowers … all have become familiar back-drop reports to our unhappily neoliberalised NHS.

Such fractious and pathogenic contentions were extremely rare in my first 20 years of practice: the fact of their current frequency surely tells us much about our discordant misdirection.

In the last year there have been several legal challenges to these kinds of alleged miscarriages of institutional procedure and probity. Publicity and supported contention has been provided by, for example, The Centre for Welfare Reform, Doctors Association UK, our NHS our concern, and Doctors for the NHS. Recently I was invited by the latter two organisations to petition against what, again, sounds like a collection of egregiously perverse misapplications of institutional procedure: they will challenge the specious procedures with correct procedure.

I will support these challenges but wish to go much further. Where is that?

The more laws, the less justice

We have here, I believe, a much greater problem than whether correct procedure has been followed. Legality is a frail buttress against a miscreant or bad culture: the law's ethical integrity is only as good as its practitioners. And so, it seems to me, a profoundly misdirected (at least) culture that is so often procedurally corralling, silencing or eliminating its welfare practitioners is likely to be well armoured against legal challenge.

The Stasi, with Germanic thoroughness, had many legal and policing devices and staff to deal with the dissidents and the inconvenients of the GDR. I don't know how many (if any) legal challenges there were to the GDR's hegemony, but even if they were successful what chance did any have of substantially

changing the underlying totalitarian culture? As far as I'm aware, it was the collapse of this totalitarian system that neutralised the draconian powers of the Stasi and GDR courts, not any formalities of legal process.

A worrying part of this problem is that, with few exceptions, officials exercising and abusing such draconian powers appear to sincerely believe in the ideology that exonerates their actions. Officials in police states are usually otherwise unremarkable citizens who wish to side both with power and the right side of the law, whatever that happens to be. There are many reasons for this: retaining occupational status, security and livelihood are obvious. But protecting a good self-image is another; cognitive-dissonance threatens this – we can keep that at bay, by denial, rationalisation and doctored data. This is what happens when mistaken paths become culture.

So it is that totalitarian systems, by nature, have few ready portals for challenge. And in this culture-medium our neoliberalised NHS has produced a fascinating variation of totalitarianism: we have – amazingly – managed to fuse the paralysed, paranoid, dispirited repression of the Soviet Bloc with the venal, opportunistic, heartless and intimidating cunning of the worst of USA capitalism. This is like a monstrous child misbegot by two struggling yet coupling parents.

A way forward?

I was talking of this with a senior manager, SM, of a large multinational organisation. He laughed with a kind of ironic, pitying recognition and then said, 'Look, this is just how it is in our large corporations: that's how they operate. You shouldn't be surprised, and you certainly shouldn't take it personally… If I publicly challenged the ethos or strategy of my company I would be side-lined or eliminated very quickly. That would happen usually with great skill and stealth. How do they do it? Well, you'd best ask our HR or Legal Department – they're very good at it!'

He smiled warmly, with a brief flash of strong white teeth. I felt a chill run through me.

I thought later about what SM had said. He was certainly right about large commercial corporations. It would be equally true in any dictatorship and any totalitarian organisation. And it is what we are struggling with now, in our NHS.

Yet this is a relatively recent development. Almost all older practitioners remember a very different service which – for all its unevenness and lesser capacity – somehow remained free of these traps. The kind of fractious and unhappy discord now so evident, was almost unheard of then … and the NHS was able to offer an overall quality of service, then, that served as a worldwide beacon and model.

So if – as I believe – our NHS is more helpfully viewed as a living organism, rather than a machine – then we can ask: what does it need in terms of protection, modelling, nourishment, living space, ambient relationships, motivational understanding, caring recognition…? If we can replant our best answers to these questions, we shall be much freer of many of our nefarious and tribulated tangles.

Hopefully legal and procedural challenges might, at least, help us focus on this larger task.

Notes and further reading

The interested reader is, referred to the websites of Doctors Association UK (www.dauk.org), The Centre for Welfare Reform (www.centreforwelfarereform.org), our concern our NHS (www.ournhsourconcern.org), and our own site (www.doctorsforthenhs.org.uk). Many of their publications provide much background data, evidence and examples in support of the arguments developed here.

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DOCTORS FOR THE NHS
SERVICE NOT PROFIT

A brief Presidential history of our organisation, what it has achieved, and where the future challenges lie

The NHS Consultants Association (NHSCA; DFNHS's forerunner) was formed in late 1976. The Health Secretary at the time was Barbara Castle who wanted to have complete separation between the NHS and private medicine by moving private beds out of NHS hospitals.

The BMA was outraged at this. They advised their members to take industrial action by "working to rule". Paul Noone and two colleagues wrote to the *Lancet* deploring this and inviting like-minded colleagues to join them. Many of us did and we set up the NHSCA for those whose overriding commitment was to the NHS.

The early activity centred round trying to ensure that an "NHS only" contract remained a viable and attractive option and presenting evidence to the Royal Commission on the NHS

1987 saw the first edition of our quarterly journal, then called *Specialist* and edited by John Duncan.

In 1989, faced with the prospect of the government of the day bringing in the Internal Market, NHSCA brought together a number of other organisations and set up the NHS Support Federation with Professor Harry Keen as its Chairman. Over the years this has changed its function to being primarily a research and information gathering body with which we remain in contact and support financially.

Meetings with politicians

Over the years officers and EC members have met and put our views to a succession of Health Secretaries and Ministers and to their Shadows, including Brian Mawhinney, David Blunkett, Margaret Beckett, Stephen Dorrell, Tessa Jowell, Harriet Harman, Chris Smith. Frank Dobson, Sam Galbraith (responsible for Health in the Scottish Office) Simon Hughes(Lib Dem), Ann Widdecombe, Philip Hammond, Alan Milburn, Liam Fox, Andrew Lansley, John Hutton, Paul Burstow (Lib Dem), Ara Darzi, Mike O'Brien, Lord Howe, Diane Abbott, John Healey, Andy Burnham, Norman Lamb and a meeting with Caroline Lucas (Green) which revealed very considerable agreement on health issues.

Meetings have also been held with members of the Health Committee and we have twice actually been represented on the Committee by first Richard Taylor (Independent) and more recently by Phillipa Whitford (SNP). There has been repeated contact with the recent Chairman, Sarah Wollaston and we have contributed to the Committee's Inquiry into ACOs.

In 1995 Birmingham Consultants for the Rescue of the NHS applied to amalgamate (the Autumn 1996 Newsletter records 32 new members in 3rd quarter of that year including such well-known names as Allyson Pollock and Jacky Davis.)

Consultations

The Association presented evidence to many consultations including those on Freedom of Speech for NHS Staff, a Labour Party document "Health 2000", PFI, a White Paper in 1997 by the incoming Labour government on how the Internal Market could be removed!

In 2000 a response to the report of the National Beds Inquiry and the following year to the Health Committee's Inquiry into the Role of the Private Sector in the NHS. Individual members have made in-depth studies of other issues and reported on them, including Top Up payments, Whistleblowing, TTIP and Care data.

In 1997 the Hospital Consultants and Specialists Association (HCSA) protested about us using initials similar to theirs and asked us to change with a veiled threat of legal action. We pointed out that NHSCA predated HCSA by a number of years and heard no more about the matter.

In the same year dialogue was established with similar organisations in the USA (Peter Draper) and Spain (Peter Fisher) with reciprocal visits to speak at meetings. In the case of Spain this continued for many years and we still exchange journals with the Spanish Federation of Associations for the Defence of Public Health (FADSP). From them we learned that Foundation Hospitals, an early example of which near Madrid inspired Alan Milburn to introduce them in England, had never numbered more than a dozen in Spain and almost all later returned to traditional management.

In 1998, at the invitation of the Royal College of Physicians we organised a conference at the College "The Future of the District General Hospital". Also in 1998, we played a major role in the 50th Anniversary Celebrations of the NHS held at Tredegar, Wales.

NHSCA worked with a coalition of campaign groups and trade unions, Foundation Trust Concern, to oppose the Health and Social care Act 2003.

In 2005 seeing the need to set up an umbrella organisation NHSCA, together with NHS Support Federation and London Health Emergency, formed Keep Our NHS Public which was launched at our AGM to which other organisations and individuals had been invited. KONP has now taken on a major campaigning role with active branches round England. We retain a close connection, with some of our members playing leading roles, and we continue to provide some financial support.

Publications

Publications including responses to official consultations have been numerous. The Newsletter for March 1998 carries a list of 24. Amongst these were a paper on low morale in the NHS prepared at the invitation of Stephen Dorrell and three publications from the Health Policy Network, a group set up and led by Peter Draper. The first of these, *In Practice – the NHS Market*, demonstrated using official figures that the very limited internal market had virtually doubled administrative costs.

Speakers have been provided on numerous occasions in the UK, including the Green Party Conference, and overseas such as the International Association of Health Policy Congress in Majorca (2002) and other meetings in Spain.

There has always been strong representation in Scotland and we followed with great interest the initial grass roots movement in the Borders Region in 2002 which led to the full integration of the hospital service with primary care. The following year members met Malcolm Chisholm, Scottish Health Minister, shortly before the integrated system was introduced throughout Scotland. In 2004 the Scottish Health Campaigns Network was established with NHSCA members playing major roles and ensuring that issues in Scotland were given prominence in NHSCA discussions.

BMA links

DFNHS has had official representation on CCSC and several members are active on the

BMA Council.

In 2010 NHSCA with NHS Support Federation and KONP initiated a round table conference on "An NHS beyond the Market", hosted by the BMA.

From 2011, NHSCA political activity centred around opposition to the Health & Social Care Bill. Taking the message to the public through our website, a presence on marches with our own banner, display of car stickers etc. Members played a significant role in this opposition, through their Colleges, letters to their MPs and speaking engagements. Following the passage of the Bill attention turned to secondary legislation on Section 75 which introduced competitive tendering.

Doctors for the NHS

In 2014 at a Special Meeting of the Executive Committee it was decided to open membership to General Practitioners and all doctors in training. This necessitated a change of title and "Doctors for the NHS" was agreed. The website was redesigned and a part-time Communications Manager (Alan Taman) appointed. The renamed and expanded organisation was formally launched in March 2015 at a meeting in parliament hosted by Frank Dobson MP.

Recent activities have included support for the NHS Reinstatement Bill and the application for Judicial Review of the introduction of Accountable Care Organisations. Members of DFNHS are playing leading roles in both these projects.

Many members are active in local campaigns to prevent the downgrade of their hospitals under Sustainability and Transformation Plans and at national level.

DFNHS is represented on Health Campaigns Together and involved in its activities, reflecting the fact that there are now many more health campaigning organisations at local and national level than even a few years ago, as realisation about privatisation and under-funding of the

NHS becomes more widespread and groups and communities throughout the UK see local services reduced, privatised or closed. The Executive Committee meets regularly in London (lately, online!). The AGM and Annual Conference currently alternate between London and York with invited speakers introducing current topics for discussion. The Newsletter in printed form goes out quarterly to all members as well as via the website and there is regular email communication with them. DFNHS has its own social media channels, which are being developed to keep pace with the way members of the profession now communicate.

Over the Years ...

DFNHS has a long and successful history. When it was first set up, there were no specialised health campaigns aimed at fighting privatisation of the NHS and the erosion of services we have come to see, especially since the passing of the Health and Social Care Act in 2012 – but as this short history shows, the seeds of destruction were sown long before then, and DFNHS (or as NHSCA) has always opposed them. The expertise, standing and motivation of its members have always been its core strength. We are doctors. More than that, we are doctors with a passion for the principles of the NHS, and a determination to uphold and strengthen those principles by persuasion wherever we may.

Looking Ahead

But we no longer stand alone. The growing crisis in health service provision and a succession of ideology-led governments, hostile to the very ideals of the NHS, has seen new campaigns set up with aims similar to our own. We work with them. Many of our members act locally or nationally with these 'new kids on the block'.

Recent months have seen a number of new challenges and opportunities, a period of political instability following an inconclusive general election, followed by a further election producing an apparently unassailable majority but with multiple manifesto commitments which it must be made to honour.

Now we have the very serious threat of coronavirus and its massive effects on the NHS, both in terms of short-term change to deal with the pandemic but also in terms of more uncertain, longer-term shifts in practice that running the NHS with the presence of the virus demand. There have also been serious shortcomings in the provision of personal protective equipment (PPE) to healthcare staff, the track and trace system, and the policy changes made (or omitted – see David Byrne's and Malila Noone's articles in the April 2020 Newsletter, for example) to cope with the pandemic. At this stage it is important to ensure the least bad outcome but later those responsible for the NHS being in so weakened a state to deal with this crisis must be held to account. This means not just the years of underfunding but the failure to see and investigate, let alone take corrective action, on the worsening recruitment and retention of so many categories of NHS staff.

In this rapidly changing situation our policy remains as it always has been – to work with anyone who shares our aims whilst remaining unaligned to any political party. Those aims, as stated on our website, can be summed up as:

- Restore the NHS as a publicly funded, publicly provided and publicly accountable service.
- Secure fair access to health services based on needs not wants.
- Promote professional and public involvement in evidence-based planning of health care services.
- Highlight current problems and controversies faced by the NHS and suggest solutions to them.
- Help medical colleagues engage with policy making and management.

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Covid-19: our response so far

DFNHS achieved early national press coverage on the woeful state of PPE provision to NHS staff, with quotes in both the *Daly Mail* and *Daily Mirror* on the same day (almost unheard of!), adding our more experienced voice to 'front-line' organisations such as *Doctors' Association UK*, whom we liaise with regularly. We have since been quoted in the *Guardian* about the use of private hospital facilities during the pandemic while NHS beds now lie empty. We have added our voice to *We Own It's* petition campaign to remove the track and trace contract from Serco, while public-health expertise in local authorities is systematically ignored. At least one local community tracing project using local expertise and engagement, in Sheffield, has already been shown to be far more effective. [Summary at: https://bit.ly/2BfyviH]

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