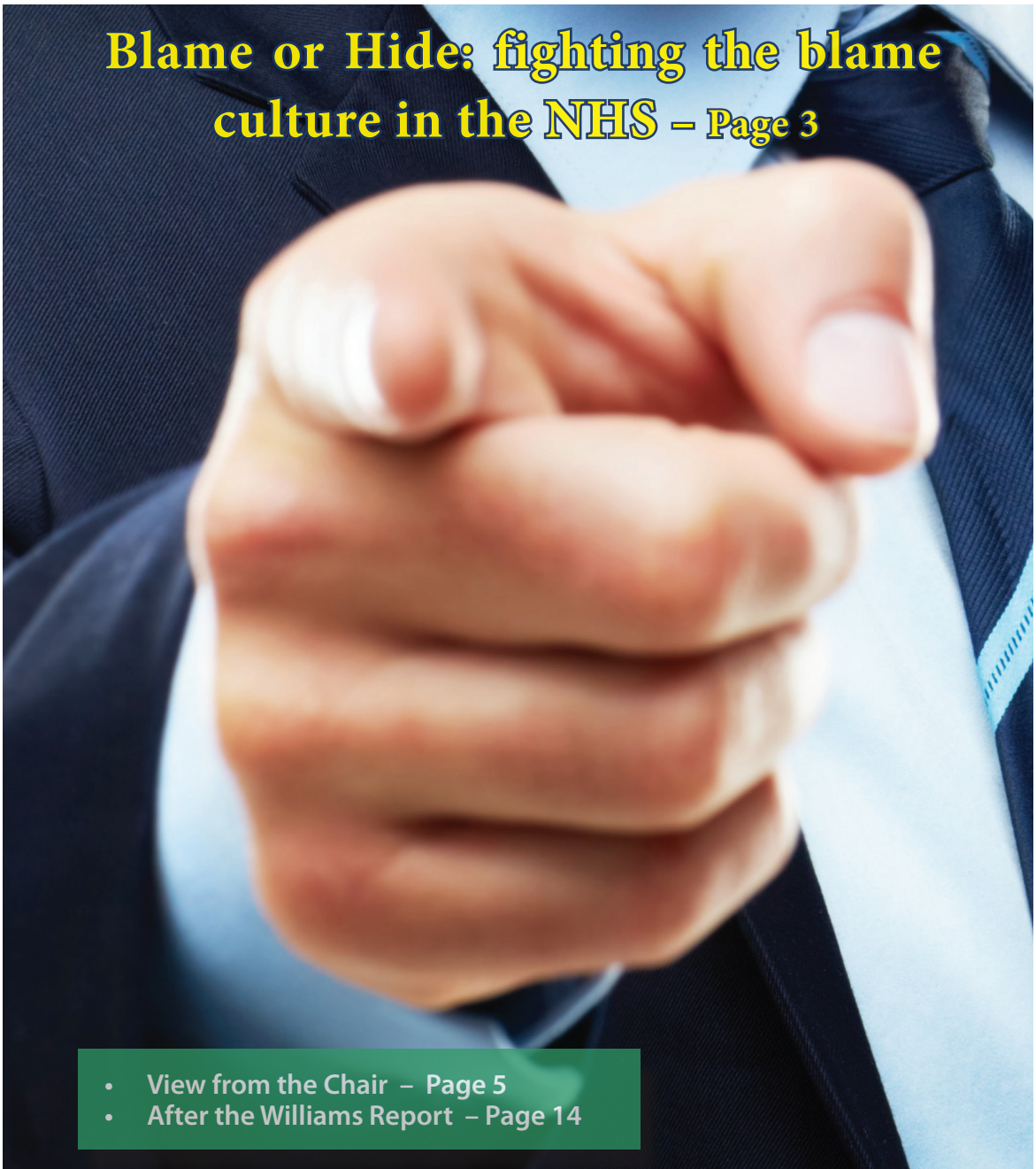
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Blame or Hide: fighting the blame culture in the NHS – Page 3



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A Place of Safety?

It is safe to say that the NHS now continues to face one of, if not the, greatest threats to its existence in all its history.

The pandemic has taken a terrible toll, with many lives lost. Many of our colleagues, and indeed our own members, have been in the thick of it, dealing with human loss and personal pain on a daily basis at a scale rarely seen outside warfare, and most if not all will have been facing this for the first time in their careers. This has left many doctors and healthcare staff totally exhausted, in a service that faces the prospect of trying to deal with the huge backlog of cases that were not seen during the pandemic – assuming we see no more waves of infection. In such an environment it will be all too easy for the spectres of bullying and blame to add to the misery, in an NHS already impossibly strained with staff who are already struggling to cope. Colleagues are facing almost insurmountable delays, impossibly over-booked facilities after months of being unable to use them at all, and the ongoing need to use Covid precautions.

Little wonder, then, that the NHS is threatened with increasing numbers of people leaving, rather than face the prospect of being blamed for all the delays. Or with people blaming others when they feel that is the only way to avoid it themselves. This is no time to resort to bullying and blame: but that culture could well worsen at the very time we need to nurture the NHS, and the people who run it, more than it ever has been.

Sir Norman Williams, in his article about the Report into Gross Negligence Manslaughter (GNM) (see page 14), describes systematic failures that most often surround patient safety, and the tendency still all too apparent to blame the individual, which does not help in creating an environment where patient safety is central. Ostracising individuals means the real reasons as to why an error has happened at that time with that particular patient are never determined. Sir Williams' Report did a lot to focus attention on the GNM end of the spectrum, but looking at the ideal of a 'learn not blame' culture for the NHS shows that this is currently not happening as much as Sir Norman and others would like it be happening, particularly down at the 'grass roots' trust level. At GMC and trust disciplinary hearings and in the day-to-day culture of the NHS, much of the thinking around systems failures and weaknesses seems woefully absent. Are individuals still being exploited so that the fact that the system is not working can be ignored?

When something goes wrong with patient care or someone suffers, it goes without saying that this is not what healthcare professionals set out to do. Making them victims causes a great deal of personal pain but also makes it far more likely that their colleagues will perform an 'ostrich act' of denial, because they do not want to draw attention to themselves or they think things cannot be changed or fixed. Anything further away from a 'learning culture' which does not use blame would be hard to imagine.

Dr Jenny Vaughan, Chair of the Doctors' Association and a national leader in 'Learn not Blame' culture, believes that the criminal law is a very blunt tool when it comes to dealing with doctors who make honest errors. The NHS simply cannot aspire to become one of the safest healthcare systems in the world unless it truly adopts a more just culture. Although there have been some improvements since the Bawa-Garba case, she remains very concerned at how healthcare workers, especially those from an ethnic and diverse background, are treated. The Williams review was followed by the GMC gross negligence manslaughter (GNM) review led by Leslie Hamilton. There were several key recommendations in relation to experts as well as one which stated that an appropriate external authority should scrutinise the systems within the department where a doctor worked in a GNM investigation. To date there is still not a consistent

approach especially in the area of external scrutiny.

Dr Vaughan often finds herself assisting doctors who have been wholly blamed for mistakes which have occurred on a backdrop of a raft of system errors. She led the successful appeal for David Sellu and notes the complexity of healthcare and the fact that a jury is necessarily much more dependent on expert reports to come to a just verdict. A criminal conviction can result in the incarceration of the healthcare worker involved and loss of livelihood, not to mention the extreme effects often on the physical and mental health of the individual. One must however ensure that patients and their families have confidence in the system. Relatives have often been put through a long and torturous process and deserve to have a full and frank apology, investigation and explanation of why their loved one died and where there has been avoidable harm.

Overall she believes there needs to be more accountability at an organisational level to ensure fairness and allow for system errors to be properly scrutinised alongside human factors. The Academy of Medical Royal Colleges did publish guidance on expert witnesses as recommended by the Williams review and this has undoubtedly led to some improvements. However, it's still much harder to hold the system to account and easier to blame one or two individuals. She remains concerned about any tendency to downplay the role of the organisation in order to try to show just how egregious an individual's decision-making was so that the threshold for a criminal prosecution can be reached.

Patient safety is paramount. Expert witnessess must ensure that their reports demonstrate an understanding of 'all the circumstances' in which the individual is placed. Reflection on and an understanding of how these factors impact on the individual under investigation and their decision-making is vital. Dr Vaughan also believes that there should be a more flexible system to allow any concerns about particular experts to be taken forward. Don Berwick remarked that 'fear is toxic and blame should not be used as a tool,' when asked to conduct a review after the public inquiry into the neglect at Mid-Staffordshire Hospitals. A new culture of openness and transparency is vital for patient safety. This should apply to all of those involved, including expert witnesses who are well-paid for their reports and should operate at the highest standards of probity and behaviour.

Thus both Jenny and Sir Norman make it plain that there is a great deal of work still to do to protect our holy grail of patient safety and deal with doctors errors and mistakes in a constructive and learning manner.

Sir Norman further comments that when it comes to diversity reporting, BAME doctors are still facing a higher likelihood of facing disciplinary action in their professional lives. So are they selected to work in failing systems, or are they seen as more vulnerable and easier to vilify? As far as I can tell all GNM convictions have been of doctors of BAME origin, every single one.

The proposed White Paper on Integrated Care (see page 9) acknowledges widespread systems failures, and proposes replacing these with untried and untested new systems, the details for which are currently not being disclosed. What we do know is that those who will be delivering the frontline care are not being looked after in these 'top-down' proposals. Why the current system is not working is not really considered. Is this because the system is under pressure, especially on the workforce?

As we face what remains a very uncertain time, the NHS now needs unprecedented investment if it is to continue in the spirit in which it was founded and give the best possible care to all who need it, irrespective of income, class or creed. That investment must of course place patient safety and welfare front and centre. But those charged with ensuring we do still have an NHS that delivers the political promise would do well to remember: the people who make the NHS work need to work without fear.

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View From The Chair: Does it Really Matter?

Thoughts on the government's latest White Paper proposing changes to the NHS, and what it may mean

The Government's White Paper, "Integration and innovation: working together to improve health and social care for all" (1) was published in February, confirming that the calls from NHS England and others had at last been heeded: to replace much of the unworkable mess of an organisational framework that had been put in place by the Health and Social Care Act 2012.

Over the intervening years, demands made of our political representatives to support an NHS Reinstatement Bill (2) had largely been rejected, using the argument that there was no appetite amongst the public, or professionals, for another major reorganisation. England has now apparently regained that appetite, but the proposals seem to do more to address the concerns of those administering the health service than those of people who depend on those services, or work on the frontline, delivering those services. Does the proposed reorganisation bring the health service closer to the principles fundamental to DFNHS, or does it take it still further towards one in which the NHS is used as a vehicle to channel public funds into private pockets, before that money gets anywhere near the consulting room or operating theatre?

Much of the first half of the White Paper seems almost to have been written with the aim of putting off any but the most determinedly nerdy NHS anorak or journalist. It is vague and repetitive, labouring the point that previous legislation is unfit for purpose and that collaboration is better than competition in the delivery of health services. I think many of us have been making that point for quite a few years! But it would appear that many commentators have understandably stopped reading at this point and have been happy to accept that the proposed changes represent a rolling back of the market in health and social care and are generally A Good Thing. It is only once you get to the annexes to the White Paper that the framework for future legislation becomes at all clear, and if you are short of time or patience, I suggest you skip straight to Sections 5 and 6 of the document.

DFNHS has already submitted evidence to the Health and Social Care Committee of the House of Commons, (3) as detailed elsewhere in this Newsletter (see page 9) and this necessarily emphasises our concerns that the proposals do not get rid of the market in health services – they simply replace a regulated market with an unregulated one, and we have recently seen what can go on when a government feels able to disregard those regulations. They profess to increase democratic accountability for health and social care, but by hugely strengthening the powers of the (democratically elected) Secretary of State, while dramatically weakening those of (democratically elected) Local Authorities. They do nothing to address the key requirement for an effective workforce strategy, which is essential to every element of the service. How can effective legislative integration of health, social care and public health be drafted when no proposals have yet been laid for future social care or public health services – doesn't this run too much risk of future

workarounds being required?

I suspect these concerns may fascinate and infuriate members of DFNHS, but should they bother the general public, as patients or potential patients? Do they have serious implications for the care they might receive?

The two key components of the proposed Integrated Care Systems are the "ICS NHS Body", which broadly sets strategic plans for the delivery of health and care services for the population, within the funding envelope they are provided, and the "ICS Health and Care Partnership", which includes organisations that either deliver services themselves, or through sub-contracting. The membership of both of these key bodies is very loosely defined. An ICS NHS Body may include "others determined locally". It is unclear whether this could include private companies offering commissioning support functions, private hospital groups, nursing home chains and other private companies that may have both a say in the range and scope of services to be provided and put themselves forward to deliver those self-same services.

There must exist the possibility that commercial organisations will find themselves in a position to influence strategic decisions so that they fit best with their preferred business model, draft the contracts to provide those services and would place themselves in pole position to gain those contracts and maximise the profit they can generate. At the very least, there should be a strong system of governance and high levels of transparency to allow public confidence that these huge sums of public money are being directed to solving the most urgent problems and that their effectiveness can be scrutinised. Surprisingly, there is no mention of how scrutiny of these bodies might take place, at the same time as such commissioning arrangements are to be taken out of the scope of Public Contracts Regulations 2015.

We are frequently told that the public are not bothered whether their NHS treatment is delivered by a private provider or by the NHS, as long as it is free at the point of use and of good quality. Public provision of health services has been a central plank of DFNHS's objectives since its formation. Have we been delusional? Are we really so out of touch with the sentiments of our patients and the wider public? Evidence suggests that the public are concerned about who provides their care, and increasingly so, possibly as a result of their actual experience of the market-based system.

> "Even before the pandemic there was ample evidence that the market has not produced a flexible, cost-effective, resilient health service....Any organisation that is struggling to retain staff really does need to take a long hard look at itself "

The Health Foundation has commissioned a series of studies of public perception of the NHS from Ipsos MORI, which suggests that in 2014 there might have been considerable ambivalence, when only 39% of those polled expressed a preference for their NHS treatment to be carried out in an NHS facility (4). In contrast, by 2019, preference for treatment in an NHS facility had increased to 60% of those polled, with only 28% expressing no preference (5). Why might this be the case? Are the public also deluded?

The priority for any private company is to maximise its profits within the scope of the law, whereas the priority for a patient is to receive the best and most appropriate treatment for their condition. These objectives are not always compatible, and the patient is not likely to be in the strongest position within this relationship. This

power imbalance already exists in the NHS, but not usually fuelled by financial motivation. Decisions on whether a problem requires investigation, which specific investigations to undertake, thresholds for treatment and what treatments to offer can all be influenced once the need to minimise cost enters into the equation. To be sure, no conscientious doctor would wilfully fritter away public monies, but this question does not usually weigh heavily in most clinical decision-making in the NHS – the patient's interests come first, and they can be confident that they are being offered the best treatment that clinician is able to provide.

Profit can only be maximised by reducing costs and when the greatest part of these costs is tied up with the number of staff that are employed and their level of professional expertise, it is no surprise that staffing levels are the first area to be cut when services are contracted out to the private sector. Another reason for patients to have greater confidence in a publicly-delivered service.

Costs can also be contained, and potential profit maximised, by reducing the physical locations where treatment can be obtained, by centralisation, or by eliminating the need for physical space at all, by offering a digital-first service. We have seen these processes at work in the retail banking system, with its detrimental effect on small businesses in our market towns – it doesn't take very long for a digital-first strategy to become a digital-only business model. Fine if you live in a city, have access to cheap, accessible and reliable transport, and have the skills and technology to engage online services, but otherwise it will add hugely to existing health inequalities.

If Payment by Results introduced perverse incentives, to maximise a private health provider or a hospital trust's income by treating as many people as possible, with the risk that some people might be encouraged to have treatment they didn't really need, the demand for Integrated Care Systems to keep within their allocated budget introduces the reverse perverse incentive – to maximise profit by reducing the amount of care

provided to the minimum possible. Whole services have been deleted already under the impact of austerity policies: the public need to be aware that the new proposals run the risk of driving this process much further and faster. If people are sceptical, they need look no further than the state of NHS dental services, which are only funded to deal with 20% of need, and which have spawned an environment of for-profit services to exploit the gaps, and finance schemes to help patients meet the costs and where the inverse care law flourishes.

Obviously, this is only a White Paper and we have yet to see the details of a Bill. We may be told that we are wilfully misinterpreting the intentions of these changes, in which case the Government should be grateful to us for pointing out such ambiguities so that the legislation can be drafted in a way that precludes such misinterpretation. If the legislation offers opportunities for commercial interests to trump the public good, those opportunities will inevitably be seized, sooner or later.

The public recognise the impact of the commercialisation of the NHS on the services they receive. It is up to us to make sure they and their political representatives, and our colleagues who work in and are committed to the NHS, understand the risks of this being turbo-charged by the proposals in this White Paper and demand a different route out of the wreckage wrought in 2012 by the Health and Social Care Act. If the time is right for another upheaval in the English NHS,

we must do all we can to restore it as a publicly provided, publicly accountable system founded on a public service ethos and professional standards.

References

[1] Department of Health and Social Care (2021) *Working Together to Improve Health and Social Care for All?* (White Paper). Available at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

[2] UK Parliament (2019) National Health Service Bill. Available at: https://bills.parliament.uk/bills/2282

[3] Doctors for the NHS (2021) Evidence to the Health and Social Care Committee of the House of Commons. Available at: https://www.doctorsforthenhs.org.uk/wp-content/uploads/2021/03/Evidence-to-Health-Select-Committee.pdf

[4] Health Foundation (2017) *What Does the Public Think About NHS and Social Care Services?* Available at: https://www.health.org.uk/publications/reports/what-does-the-public-think-about-nhs-and-social-care-services

[5] Health Foundation (2019) *Public Perceptions of Health and Social Care: Results from an Ipsos MORI poll commissioned by the Health Foundation for the 2019 General Election.* Available at: https://www.health.org.uk/publications/reports/public-perceptions-of-health-and-social-care-2019

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FOR THE NHS NOT PROFIT

Going Bi-monthly

This newsletter will be going to bi-monthly production from this issue. Editions will be printed for April-May, June-July, August -September, October-November (to coincide with our AGM), December-January and February-March.

This will allow more timely reporting of current issues, and allow a more comprehensive and deeper coverage of issues affecting the NHS as they develop, from a wider range of authors. The pandemic has seen an unprecedented increase in the number, pace and severity of threats to the NHS and our colleagues. Increasing to bi-monthly will allow us to keep members informed more often for very little additional cost. This will increase the number of newsletters you receive from four to six yearly. All issues are also kept on our website (www.doctorsforthenhs.org.uk/newsletters)

White Paper on Integration and Innovation: working together to improve health and social care for all

Colin Hutchinson, DFNHS Chair, presented the following evidence on behalf of DFNHS to the Health and Social Care Committee of the House of Commons

Doctors for the NHS is an association of doctors, from all specialties and disciplines, that have a strong commitment to the founding principles of the NHS, which are as relevant today as they were in 1948. It is not politically aligned, but recognises the importance of the political process in shaping health and care services.

Within our membership we retain extensive experience of working within the NHS over the span of many decades, which allows us a long-term appreciation of the various organisational and clinical changes that have taken place in turbulent times. We wish to use that experience to contribute to the evidence before this Committee.

Doctors for the NHS (DFNHS) respects the aspiration of the White Paper to bring together health and social care services within a structure of Integrated Care Systems across England and agrees that collaboration is a stronger foundation for such integration than competition.

We welcome the use of the powers of central government to increase fluoridation of water supplies to improve the developing teeth of children, given the difficulty of local authorities to coordinate such action across the whole water supply from our rivers, which does not often respect political boundaries;

We believe that the concept of a Health Services Safety Improvement Board could at last provide a safe space for candid reflection on factors contributing to adverse incidents, rather than seeking to attribute blame to individuals working within a complex environment.

We agree that Local Education and Training Boards have proved an unnecessary and ineffective addition to educational structures and should be abolished.

Is the context right for major reorganisation?

The White Paper makes many references to learning from the experiences of the pandemic, but a systematic and open review of the pandemic response has not yet taken place, so how can we be sure that the appropriate lessons have been learned? Many of the measures outlined have been under discussion long before the pandemic struck. DFNHS is concerned that they do more to address the concerns of those who administer health services than those of the people who use them, or work on the frontline.

Reference is made to major proposals to reform social care and public health services, but it does seem peculiar that structural bureaucratic changes are being progressed before the anticipated changes in social care and public health have been revealed. How can we be confident that the new structures that have been described will align with

the functional needs of these important services? If they don't, further major reorganisation will be required. Surely it would be sensible to consider form and function together.

There is now much greater awareness of the likelihood of further pandemics in coming years. Maybe consideration should be given to full re-integration of public health departments into the NHS in England, as they are in all other UK nations. These were all in a very much better position to carry out their own versions of "test and trace", having retained the necessary skills within effective local public health departments, and being able to expand from that base to meet the need. By comparison, the rapidly assembled national system in England has performed woefully in its key role of effective contact tracing, even once testing capacity had been ramped up, at exorbitant cost to the public purse. Diverging health systems in the four nations bring few advantages, but being able to learn from comparing good practice is surely one of them.

"The rapidly assembled national system in England has performed woefully in its key role of effective contact tracing ... at exorbitant cost to the public purse "

The elephant in the room

The Health and Social Care Committee of the House of Commons has recognised that the lack of effective planning to ensure a sufficient supply of suitably trained doctors, nurses and other clinicians is having a devastating impact on the ability of the NHS to fulfil its role. [1]

Retention of such staff has also been long identified as a problem, particularly when clinicians feel strongly that they are not being given the resources and support to use and they feel that the care that they are able to provide does not meet the standards they set themselves and that their patients deserve.

Shortages of appropriately trained staff is also the principal driver behind many reconfigurations of clinical services, is a key contributor to stress in the workplace and a major factor in reducing the safety of patients.

Workarounds to cope with numbers of trained staff, including flexible deployment of clinicians across wider organisational boundaries, ignores the importance of working in tight professional teams, in familiar surroundings, where each member of the team knows the capabilities, and the weakness, of other team members and how to use them to their patients' advantage. Place them in unfamiliar teams and they become less effective and patient safety suffers. This is the main reason why reliance on short-term agency and locum workers is a common feature of struggling services. We need to be strengthening teams, rather than diluting them.

The workforce models that these reorganisations favour ignore the importance of continuity of care in safe and effective treatment. If somebody suddenly falls ill, their priority is for their problem to be diagnosed and appropriate treatment started as soon as possible, so they can be cured and get on with the rest of their life. But for very many people, their ill health is due to a long-term condition that can be treated, but not cured. This includes much mental ill-health. In these circumstances, continuity of care from an individual clinician, or a small team, can foster the best opportunity to develop trust between patient and clinician and to follow an agreed plan of treatment, that offers the best chance to help people to live with their condition with the least possible disability. Understanding patients as individuals, and following them through the course of their illness also strengthens the job satisfaction of most clinicians and encourages staff

retention. We need to make continuity of care the norm, rather than an exception and organise our health services accordingly.

DFNHS finds it difficult to understand why it is thought that a new duty for the Secretary of State to publish a document once every five years should be seen as a sufficient strategy to address a problem of such magnitude. No agreed, costed, workforce plan for the NHS in England has been produced to accompany the Five Year Forward View (2014), or the NHS Long-term Plan (2019), despite the considerable implications for workforce within both these important documents.

Discharge to Assess is promoted as a means to reduce the duration of hospital stay, and nobody would wish to prolong such stay if there is a more suitable environment in which to continue recovery from illness, but a recent report from Healthwatch and the Red Cross has raised significant concerns as to how Discharge to Assess has been working in practice. More than 80% of patients who were discharged from hospital under these arrangements did not receive an assessment following their discharge. [2] It is vital that such gaps in continuing care are addressed before Discharge to Assess becomes the default pathway.

Commercial contracts or professional standards: which forms the strongest foundation for integrated patient care?

DFNHS regrets that, over several decades, the restructuring of the NHS in England into a host of contractors and subcontractors governed by commercial contracts and competition that has been focused on headline costs, rather than cost-effectiveness, has been profoundly damaging to patient care and the stability of health services. Safe, effective health care demands the creation and development of stable teams of skilled and multidisciplinary professional staff. Building up such teams and bringing together the resources

they require takes many years to achieve, as do the relationships with the broader health and care services which form the context within which they care for patients. The relatively short timescale within which the retendering and awarding of contracts operates profoundly undermines the creation of high performing teams. For teams that perform poorly, there are better ways of improving the quality of care than through a commercial contracting process.

DFNHS agrees with the removal of all barriers that impede the smooth access of patients to the care that they need. The existence of a framework of commercial contracts encourages providers to work within the confines of their contract, rather than the requirements of the patient or the professional ability of their staff. It does not make commercial sense to exceed the terms of the contract. Such contracts set boundaries to the care that is offered. Clinicians with the ability to deliver the best care that they are able, and with the freedom to hand over care to a more appropriate person when they are reaching the boundaries of their competence, can be much more effective than a reliance of patient pathways, which rarely have the flexibility to tailor care to the specific needs of the patient in front of you. Patients too often are left to navigate their way around this complex landscape and, all too frequently, fall through the gaps between services that are not well co-ordinated in time or place. Many adverse incidents take place at these boundaries.

The proposals in the White Paper retain a system based on commercial contracts, but the ambition to remove 'unnecessary bureaucracy' removes much of the regulatory framework that ensures the award and monitoring of these contracts takes place transparently and with accountability, in line with the Nolan Principles. Far from removing the market, it replaces a regulated market with an unregulated market: recent reports from the National Audit Office [3] and from the Public Accounts Committee [4] provide examples of hazards of operating without such constraints.

Potential conflicts of interest – how will they be resolved?

The intentionally loose description of structures and their working arrangements, while appearing to be a pragmatic approach to allow flexibility to respond to local circumstances, gives us concern that they could allow a major challenge to the public service ethos which has defined our NHS since its conception.

"The proposals in the White Paper retain a system based on commercial contracts, but the ambition to remove 'unnecessary bureaucracy' removes much of the framework that ensures ... monitoring takes place transparently"

The membership of the Statutory ICS NHS Body is very loosely described:

- The ICS NHS Body may include "others determined locally". It is unclear whether this could include private companies offering commissioning support functions, private hospital groups, nursing home chains and other private companies that may, at the same time, be providing services to the ICS. This could be perceived as presenting the opportunity for conflicts of interest if these bodies, or their subsidiaries, are also providers of services. If this is not the intention, then there should be a closer definition of the kind of bodies that may be members of the ICS NHS Body. If it is intentional that this should remain a possibility, clarity is required as to how such conflicts of interest will be resolved.
- The duty of NHS organisations and Local Authorities to cooperate in delivering services, is being replaced by a duty to collaborate. This duty is going to be subject to guidance from the Secretary of State as to what delivery of this duty means in practice. There needs to be clarity as to the potential impact of this duty on the powers and resources of Local Authorities.
- The duties of the Body are binding upon all bodies participating in the ICS, but it is unclear whether every Local Authority in the area covered by the ICS will be represented on the Body.

The ICS Health and Care Partnership is also described very loosely:

- The wider, undefined membership of the Partnership may again include non-statutory bodies and private providers of services.
- The powers of the Partnership seem to depend entirely on those defined by the particular ICS NHS Body.

Joint Committees may be set up by the Partnership, which can take decisions which are then binding upon the Partnership, with no limit as

to the kind of provider that can be a member. There would appear to be considerable opportunities for provider organisations to select the kind of work and the way in which it is delivered in ways that would be most profitable to their organisation, with the risk that less profitable or riskier areas of work could be avoided or minimised.

Transparency and accountability are essential to good governance and the maintenance of the trust of the public, but DFNHS can find no reference to any duty for any of these bodies to meet in public, publish minutes that are accessible to the public, nor the extent to which they are subject to the Freedom of Information Act.

Scrutiny of health and care services by Local Authorities may have been inconsistent at times, but has largely been possible through considering the actions of Clinical Commissioning Groups, Local Authorities and other health and care bodies. If these organisations are no longer responsible for key decisions, and it is unclear what decisions have been taken, when and by whom, the extent to which effective scrutiny is possible becomes very uncertain: indeed there appears to be no mention of such scrutiny anywhere within the White Paper.

New barriers to integration?

If the intention is to remove barriers to the effective integration between health and social care, it is difficult to understand why new barriers should be erected. Local Authorities commission services within the scope of Public Contracts Regulations 2015. The White Paper proposes removing the commissioning of clinical services from the scope of these regulations. It is unclear how joint commissioning between Local Authorities and NHS bodies will work if there are two separate regulatory frameworks.

The greatest barrier to integration between health and social care is the different model of funding and eligibility criteria between a health service that is universally accessible, comprehensive and funded almost entirely through general taxation and a social care service which operates under strict criteria of eligibility and payment for which is heavily means-tested. Only when these barriers are removed can the experience of the patient with long-term needs become seamless and the cost of the associated bureaucracy be removed.

References

[1] UK Parliament (2020) *Committee Chair Jeremy Hunt criticises failures that 'make a mockery' of NHS workforce planning*. Available at: https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/136782/committee-chair-jeremy-hunt-criticises-failures-that-make-a-mockery-of-nhs-workforce-planning/

[2] Healthwatch (2020) *590 people's stories of leaving hospital during COVID-19*. Available at: https://www.healthwatch.co.uk/report/2020-10-27/590-peoples-stories-leaving-hospital-during-covid-19

[3] National Audit Office (2021) *Investigation into government procurement during the COVID-19 pandemic*. Available at: https://www.nao.org.uk/report/government-procurement-during-the-covid-19-pandemic/

[4] UK Parliament (2021) *Covid-19: Test, Track and Trace (part 1)*. Available at: https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/932/93206.htm

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Stopping The Culture of Blame

The Williams Review into gross negligence manslaughter in healthcare was published in 2018 in the wake of several high-profile cases of miscarriages of justice. The Report's principal author, Sir Norman Williams, talks to DFNHS Communications Manager Alan Taman about the Report and how the NHS is hopefully changing – and still needs to change

How far is the NHS from a 'just and learning culture'?

This depends where you are, it's very patchy.

There are unfortunately still individuals within trusts that think along the lines of blaming individuals for mistakes, but I like to think – having had a lot of discussion with people who do believe in a just culture and want to do the right thing – that we are slowly inching towards a better situation.

I think that's come about for a variety of reasons. The Francis Report into failings at Mid Staffs was a really important moment because it brought into sharp focus the problems and a great deal emanated from that. Such as duty of candour, where trusts have to 'fess up' when they have made errors and be open about them. It also eventually resulted in the Health Safety Investigation Branch (HSIB) which is working through its programme; it started by looking at maternity incidents, for example. HSIB was modelled on the Air Investigation Branch because of their approach to transparency and the ability of people to discuss errors that may have occurred in an open manner without fear of retribution. I also like to believe that our Report on Gross Negligence Manslaughter (GNM) in Healthcare has helped by making recommendations that are slowly being enacted.

The Secretary of State at the time, Jeremy Hunt, was obviously concerned by problems with patient safety and the blame culture particularly following the Bawa-Garba case. That was a real touchstone. I had previous experience of similar cases when I was President of the Royal College of Surgeons in particular that which involved David Sellu as well as others that I was aware of, where healthcare professionals had been blamed and had been investigated by the police and then finally had been prosecuted for GNM by the Crown Prosecution Service. It seemed in the Bawa-Garba case, that there was a systems failure. Often when mistakes happen it's very rare that it's one individual's fault. There are usually various factors that play into that mistake, and it's often more than one individual's error alone that results in a tragedy. When staff were tasked with finding out what had occurred in the past it was very easy to blame one individual.

The evidence we accrued during our review showed quite clearly, that this was often inappropriate and it was wrong to blame one individual. It may have been one mistake by one individual and perhaps the first time they had ever made that mistake; but when you looked into it, it had often occurred because a whole raft of things had gone wrong. So, it was a systems failure, and the failure of investigators to investigate that appropriately rather than jump to conclusions was one of the important aspects behind the Report. We tried to make recommendations so people understood that. The Report wasn't just about GNM: it had connotations for the investigation of errors as a whole.

The 'Swiss cheese' model of how various

errors on their own do not necessarily result in a disaster but when compounded they can do so, is absolutely right: there are lots of examples how this can happen. One of the most common errors that occur in the health service are medication errors. A medication error doesn't mean to say that somebody has prescribed necessarily the wrong drug or the wrong dose, it can be traced right the way back to the pharmacy. The pharmacy getting something wrong and that being perpetuated throughout the system and people not noticing or checking, so various factors contribute to the incident.

The Bawa-Garba case was very interesting because she was a trainee coming back from a period of maternity leave. She was faced with a very difficult situation: other colleagues she was meant to be working with that day had phoned in sick, a consultant that she normally worked with who was on call and responsible was away teaching and there was another consultant standing in for him, it was a very busy period, she had a lot of kids coming in with emergencies, and there was a computer failure as well. This poor child with sepsis came in and subsequently sadly died, and she was blamed for it. You could see that she might well have made errors, but she wasn't alone – it was clearly a system failure, and that had not been fully appreciated in my view by the investigators. She ended up in court being found guilty of GNM and given a suspended sentence. This situation was really at the back of our minds when we did the Review and took evidence. We found other cases where the individual had been pursued without looking at the whole picture, and we also found that there was a great inconsistency in the way these investigations were pursued. We wanted to reduce that inconsistency. Because once you set the ball rolling it's got an impetus all of its own.

If you go back to the beginning when an error or a perceived error has occurred where a patient has unfortunately died, and investigate it properly then it is highly unlikely an individual will be prosecuted for GNM. We were very keen to ensure that the investigatory process was consistent and that appropriate training of the investigators had been undertaken. I'm talking about understanding human factors, understanding the milieu that the individual is working in, and appreciating ergonomics, where you might get failures of instruments etc that can add to that problem

It's also very important that people have an understanding about diversity issues, because we obtained evidence, which we found really upsetting, that people from an ethnic and diverse background were more likely to end up in the investigative process. It was quite clear both in the investigations and indeed in any professional regulatory matter that training in these areas needed to be improved.

If investigators of any untoward healthcare incident have appropriate training then hopefully people will understand and appreciate when an untoward event happens that it isn't one individual's fault. That's not to say that doctors or any healthcare professional shouldn't be held accountable. No healthcare professional should be above the law. You've got to have the right balance so that patient safety is protected, lessons are learnt and healthcare professionals are treated fairly and are not scapegoated.

There's also in my view public education as well. I think it's important that people do understand the complexities of healthcare. I think this is difficult, I think the media have a role to play. It's all too easy for the media to point fingers at individuals. That's an easy thing to do. Sadly, that does happen. I suppose it doesn't make good copy, if you try to explain the complexities around an unfortunate incident.

Has the tendency to blame improved?

I think that has definitely improved. I think the message has gotten through and trusts are far more supportive of people than they have been

in the past. I think there is a feeling that when something does go wrong, people are more sympathetic and are looking at other factors apart from individual failure.

We've still a long way to go. It's very important for people to feel able to admit their mistakes without the feeling they are going to be victimised. I think we're getting into that environment. There is more work to be done, and there is more support that is required, but I am more optimistic than certainly I was when we did the Report.

Do you feel the risk factors of this blaming environment are still there?

Yes, I think we need to be bearing down on this all the time. I think it needs people in positions of leadership to stand up and keep pressing on this so the system is more transparent. But I'm seeing it. There is a Freedom to Speak Up Guardian system now which wasn't there before. This system allows people to speak up when there is an error, and feel confident about doing so. This is in progress. Now the Guardians often attend trust boards and give a report about what's happening. I think it's really important to have a non-executive director on the board who has responsibility for the Guardians, to ensure that the staff are able to speak truth to power. I also think it important for members of the healthcare teams, no matter their seniority, to feel empowered to speak out if they are concerned about an incident or where they see safety being compromised. When the leader of that team is open to hear criticism and all the staff know that and they feel comfortable about speaking out then quality and safety in that team is much more likely to be improved. I think we're getting there. So, I am more optimistic. But we'll only see it when we see fewer unfortunate incidents and fewer people being blamed.

I hope people are feeling a bit more confident about things, and I hope some leaders will realise they have a responsibility to encourage the people who work with them feel comfortable about speaking up. Good leaders respect that and prefer people who are prepared to speak their mind because it helps them improve. It helps the team reach an appropriate solution. There are lots of good people out there, and there are lots of excellent leaders. But the NHS is such a massive organisation you're bound to get variation. Hopefully, gradually particularly as more and more young people come into the NHS, and are prepared to challenge the status quo, people's perceptions will change and safety will improve.

Patient safety is the bottom line

There are a lot of people pushing on this, the bottom line is about patient safety. You have to look at it always through that lens, and if you are going to improve safety in the system you have to have a culture that allows harm to be discussed in an open manner, because that is the only way you are going to improve patient safety. If you hide away from a full and frank discussion of incidents then we will never make the improvements that are necessary. Put the patient at the top of the pile then everything follows. One would hope in those institutions where things have gone wrong and they've approached this in the wrong way, there is a realisation that you are not going to be able to deal with it like that. The more open you are, as early as you can be, with the facts, the better.

[Sir Norman is commenting in a personal capacity. The Williams Review is available at: https://bit.ly/3u5q9At]

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'If I was Minister of Health': More on Democratising Healthcare

With the announcement of this year's Essay title and prize (see page 26), the runner-up entries from last year are reproduced here as a sign of the quality we can expect this year

'If I was Minister of Health': An Essay Inspired By Niccolo Macchievelli's *The Prince*

If I were Minister of Health in the current government I would be rubbing my hands with glee. What should be a difficult brief, the bane of politicians, the poisoned chalice, is so ripe for harvesting at the moment. For at the moment, and for as long as matters, my decisions are inconsequential and my mistakes are not my own. If I were Minister of Health at the present time, in this present government, I would realize what was ahead of me – opportunity.

The first thing I would do as Minister of Health would be to hold a press conference, as any self-respecting elected official, or unelected Dominic Cummings [1], would. I would open my press conference with a thank you to the outgoing Matt Hancock. I would thank him for his tireless service to this country and the effort he had put in keeping things together through the pandemic. At least, that is what I would openly thank him for.

In reality, I am tying the poor chap to the outcomes of the pandemic and the upcoming inquiry. While the Prime Minister has already done a good job of saddling him with the blame by making him the face of the pandemic [2]. By thanking him in this way I would ensure the target was thoroughly painted on his back. This ensures that no matter what I do, I will be able to avoid the lion's share of the blame. This tactic has shown tremendous success in the United Kingdom so far; us Conservatives have even managed to blame Labour for our policies and they have not been in power for years! [3]

I am also thanking him for laying the ground work for deflecting blame to the scientists. Those poor scientists who thought they were being invited to help protect the health of our country. They should have realised that we were not going to listen to their expertise. What was that phrase again? Oh right, "the people in this country are sick of experts" [4]. Thanks to Matt Hancock, and really everyone in government, I can continue to blame the science. We have been listening to it from the start and I cannot be blamed for the science being wrong.

This is the beauty of being a previously unknown minister who has been elevated to the top level. Just as Rishi Sunak – everything he does as Treasurer is seen as brilliance (even though it is secretly Labour policy). That is because the expectation of him was to flounder and crash spectacularly. As long as I do not make a colossal hash of the entire thing I will be absolutely fine. Even if I do make a hash of it, I will probably stick around long enough to do what actually matters. To do what I need to do. What I need to do, if I was Minister of Health, is make sure that when I leave, I make as much money as I can. This has to happen fast because there are so many ways that I could lose my position, for example getting kicked out by the Prime Minister for outsmarting

him (see – Julian Lewis) [5], resigning in impotent rage at being outmanoeuvred (see – Sajid Javid) [6], or getting voted out after being involved in a corruption scandal (see – Robert Jenrick if we are being optimistic) [7].

The opportunity for profiteering in healthcare has never been higher than at this moment. Which is why, if I were Minister of Health I would be salivating, while simultaneously looking for the ideal tax haven. Firstly, the existence of the pandemic allows me to funnel money basically wherever I want without any scrutiny whatsoever [8]. This is important since it can help guarantee me a cash flow in the future when I move into lobbying. As such, one of my first jobs as Minister of Health will be to ensure any PPE contracts continue to be directed towards my friends in high places, particularly any which work at Serco. This goes double for any large-scale projects like a track and trace app.

"The opportunity for profiteering in healthcare has never been higher than at this moment. Which is why, if I were Minister for Health, I would be salivating, while simultaneously looking for the ideal tax haven"

I know what you are going to say though – why should we continue to give contracts to companies that have shown [9] time [10] and again [11] that throughout [12] history [13] their strength [14] is failing [15] upwards [16]. To that end I gesture violently to Chris Grayling [17]. He and these companies have a key thing in common – they know how to massage egos and money in the correct direction. As such, if it enriches me, which as we know is the ultimate aim of any proper politician, I have no qualms over giving contracts to these companies.

That is the long game and realistically I could probably do this whenever I wanted. However, there is a juicy new limited time opportunity that I want to seize as the Minister for Health now - Brexit. As such, my second job is to make sure I have got a seat at the table for any United States/ United Kingdom trade talks for a post-Brexit trade deal. That way, I will be physically close enough to receive some very tempting donations from American healthcare companies allowing them entry into the market. Which is very much something that I can do since, coincidentally, I am not allowed to protect the National Health Service during these trade agreements legally [18] (most delightfully that extends to any other foreign interference so imagine the opportunities that open from China, Russia, and anywhere else!)

I will however come to a crossroads – having already protected my future in lobbying and pocketed money from lobbyists to spend now, the question becomes, what do I do with any remaining time in my tenure? I think at this point I won't draw inspiration from any of my recent predecessors. I'm not going to be a scapegoat like Matt Hancock, and I'm going to try not to make anybody angry like Jeremy Hunt managed to – particularly since I do not hold strong views or any ideology I would want to push. I hold particular ire for Jeremy Hunt because his ideology was based around becoming incredibly rich by privatising the UK National Health Service [19], a much more difficult way to actually get rich than what I'm doing. Remember, the true politician isn't in this because of ideology or belief – they are in this to get rich and to have an easy life.

To keep the gravy train rolling, realistically I need to get a different brief – something that either has a lot of financial opportunities through construction companies or land barons like Housing Minister, or that will allow me to exploit

financial opportunities with the financial or service industry like Treasurer. The best way to do this is to take down my opponents. Now, this may seem more difficult than just doing a good job but that would only be true if my opponents did not have any obvious public weaknesses.

If we turn our attention to my strongest competitor it would almost certainly be the Treasurer. The Treasurer overall has quite significant power, making them a threat, but this threat is doubled by the fact that he is a popular and charming Conservative that hasn't made a fool out of himself. His role however is extremely weak due to two things. Firstly, he is more popular than the Prime Minister, which means that he is on thin ice already. Secondly, he is in charge of all the money and everyone from politicians to the public quickly turns the people in charge of the money. To get rid of him all I need to do is turn the public against him.

Step one is to publicly lament that without proper funding we are not going to manage a coronavirus second wave on top of flu season. This sounds dangerously like Labour territory (and it is) but it serves two purposes. We still need those first time Conservative seats in the previous Red Wall (renamed the Blue Smear) and this plays well with them. Also, and more importantly for my power grab, this puts our Treasurer in a particularly tricky position. Either he gives me carte blanche to spend as much as I want, and I spend at an eye-wateringly high level of money (for the Conservative party, which translates to enough to pay for roughly three extra nurses and maybe one more doctor if we can find any) thereby infuriating the more fiscally conservative Conservatives, isolating himself within the party. Or, he refuses and becomes the figurehead for every single failure that happens during a second wave. No matter his choice, I win. Checkmate Chancellor of the Exchequer!

Now realistically that leaves me with Dominic Cummings as the main threat to power. The difficulty with him is that he has shown that he is

made out of Teflon to such a degree that he could almost certainly deface a national monument on live television and he still would not be sacked. This is a problem I do not know if I can solve quite yet – at present my hope is he continues to make everyone hate him so much he loses his power, the Hoskyns effect if you will [20]. To that end I am going to have to push him to be a bit more public-facing, possibly even do another catastrophic press conference. The tactical leaking of internal communications about him and the spurring of mistreated employees to sue might help to that end. I will continue to think about this issue.

To summarize, if I were Minister of Health I would look forward to the next year as a year of almost infinite possibility. I would take steps to make myself as wealthy as possible as quickly as possible, while also investing in a future source of income. I would then push forward to insulate myself with power for a long lasting life. If the government I was part of would be voted out, even then I would not be too concerned – I would make a fortune out of being an agent provocateur. I guess, ultimately, all I would do is exactly what the rest of my supposedly "right" and supposedly "honourable" would do, and I would not get caught.

Oh, and if I eventually found myself becoming Prime Minister I would struggle through a single push-up and not do much else [21].

Well, not exactly, since I am not the model of a politician. Unfortunately, I have chosen to

go into medicine instead. Which means I have learnt from colleagues and patients about what it actually means to provide healthcare and what is necessary. I have also learnt from those around me the importance of integrity and of holding values. I even respect my duties as a doctor and remain properly bound by a minimum standard of behaviour [22]. So if I were Minister of Health I would try to make a difference with adequate funding, decisions shared between managers and healthcare staff of all levels, protection from privatisation, and a million other ideas but would end up sacked within a week!

[A note: This satire and its views are quite clearly my own. I hope this does not tar me as a political theorist nor does it lead to my last name as a synonym for political deceit as The Prince *did for Macchievelli. Wear a mask, stay safe. And if you do go into politics, only take the ideas from the bottom paragraph of this essay please.]*

References

[1] Cumming, D. (2020) Press Conference at 10 Downing Street, London. 25 May 2020
[2] Hancock, M. (2020) Matt Hancock on Lorraine - ITV. 15 July 2020.
[3] Javid, S. (2019) Sajid Javid on Sky News. 5 December 2019.
[4] Gove, M. (2016) Sky News Questions and Answers. June 3 2016.
[5] Sabbagh, D. (2020) 'MP who beat Chris Grayling to intelligence chair role loses Tory whip'. *Guardian*. Available at: https://www.theguardian.com/politics/2020/jul/15/chris-grayling-fails-to-become-intelligence-and-security-chair.
[6] Mason, R., and Stewart, H. (2020) 'Javid resigned after Johnson pushed him to sack advisers'. *Guardian*. Available at: https://www.theguardian.com/politics/2020/feb/13/javid-resigned-after-johnson-pushed-him-to-sack-advisers.
[7] Walker, P. (2020) The three housing controversies Robert Jenrick is facing down. Guardian. Available at: https://www.theguardian.com/politics/2020/jun/25/the-three-housing-controversies-robert-jenrick-is-facing-down.
[8] British Medical Association (2020) The Role of Private Outsourcing In The COVID-19 Response. London: British Medical Association. Available at: https://www.bma.org.uk/media/2885/the-role-of-private-outsourcing-in-the-covid-19-response.pdf.
[9] Lawrence, F. (2012) 'Serco gave NHS false data about its GP service 252 times'. *Guardian*. Available at: https://www.theguardian.com/society/2012/sep/20/serco-nhs-false-data-gps.
[10] Townsend, M. (2013) 'Sexual abuse allegations corroborated at Yarl's Wood immigration centre'. *Guardian*. Available at: https://www.theguardian.com/uk-news/2013/sep/21/sexual-abuse-yarls-wood-immigration.
[11] Pennington, P.(2016) 'Corrections ranks Serco-run prison among NZ's worst'. Radio New Zealand. Available at: https://www.rnz.co.nz/news/national/316513/corrections-ranks-serco-run-prison-among-nz's-worst.
[12] Marsh, S. and Booth, R. (2018) 'Breast cancer screening hotline staffed by people with only an hour's training'. *Guardian*. Available at: https://www.theguardian.com/society/2018/may/04/breast-cancer-screening-hotline-staffed-by-people-with-only-an-hours-training.
[13] Perraudin, F. (2019) 'Serco given new asylum housing contracts despite £6.8m fines'. *Guardian*. Available at: https://www.theguardian.com/business/2019/jun/20/serco-given-new-asylum-housing-contracts-despite-68m-fines-for-failings.
[14] Press Association (2019) 'Serco fined £22.9m over electronic tagging scandal'. *Guardian*. Available at: https://www.theguardian.com/business/2019/jul/03/serco-fined-229m-over-electronic-tagging-scandal.
[15] Proctor K. Serco accidentally shares contact tracers' email addresses. *Guardian*. https://www.theguardian.com/business/2020/may/20/serco-accidentally-shares-contact-tracers-email-addresses-covid-19.

[16] McCoy, D. (2020) 'After PPE and testing, contact tracing looks like the next government shambles'. *Guardian*. Available at: https://www.theguardian.com/commentisfree/2020/may/28/ppe-testing-contact-tracing-shambles-outsourcing-coronavirus.

[17] Roberts, J. (2020) 'Failing Grayling': The long, long list of Chris Grayling's blunders. Metro. Available at: https://metro.co.uk/2019/03/01/failing-grayling-long-long-list-chris-graylings-blunders-8789780/.

[18] Jones, H. (2020) 'MPs vote against plan to protect NHS from US in trade deal'. Metro. Available at: https://metro.co.uk/2020/07/22/mps-vote-plan-protect-nhs-us-trade-deal-13022079/.

[19] Carswell, D., Hunt, J,, Gove, M et al. (2005) Direct Democracy: An Agenda For A New Model Party. London: Direct-democracy.co.uk; p.78.

[20] Beckett, A. (2020) 'This is the man in No 10 who inspired Cummings – and he didn't last long'. *Guardian*. Available at: https://www.theguardian.com/commentisfree/2020/jul/24/no-10-dominic-cummings-john-hoskyns-margaret-thatcher-whitehall.

[21] Ng, K. (2020) 'Boris Johnson sparks public horror after posing doing press-ups on newspaper front page'. *Independent*. Available at: https://www.independent.co.uk/news/uk/home-news/boris-johnson-press-ups-mail-on-sunday-putin-coronavirus-a9589691.html.

[22] General Medical Council (2020) The Duties Of A Doctor Registered With The General Medical Council. General Medical Council. Available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/duties-of-a-doctor.

Eliot Hurn

'If I was Minister of Health ...'

... I would not rely on my medical knowledge to make decisions.

The reason for this is simple. To create a sustainable, equitable, and effective public health system, we need leaders that do not claim to have the answers but who seek them in understanding and empowering others. The hard work in making healthcare work for everyone will not (just) lie in addressing the effects of years of chronic underfunding, but in cultivating a sense of curiosity that is the reversal of a centralised, one-size-fits-all approach of healthcare. So, in the following, I will outline how the willingness not to be an expert – what Zen practitioners call beginner's mind – could transform healthcare for the better, serving local communities, improving patient outcomes, and making the NHS a better place to work.

Care beyond compliance

In the UK, the most common causes of death are non-communicable or chronic diseases, such as heart disease, dementia (leading cause among women), stroke, and cancer [1]. This means that the main challenge for the National Health Service (NHS) has been to balance needs for prevention and treatment with cost-control, requiring alignment of health professionals and compliance of patients. Both of these have been difficult to maintain; as much as 25% of medicines prescribed for chronic conditions in England are not taken as directed, costing the NHS nearly £1bn each year for just five of the most common diseases [2]. Among practitioners, uptake of National Institute for Health and Care Excellence (NICE) guidelines is notoriously slow, and British GPs were shown to trail their international colleagues in adherence to cancer referral timelines [3].

And so we have developed a sense of expectation – both of our patients and colleagues – that people need to be living agents of the best available scientific evidence. When we see people falling short of these expectations, our natural response (certainly mine) is a mixture of disbelief and annoyance. I often catch myself struggling with patients who fail to maintain reasonable control of their condition by taking their oral antidiabetics or their insulin as directed and inevitably develop one or the other complications who lead them to have to commit to an inpatient admission. As an expert, I have difficulties coming to terms with the fact that even the best medical advice may have little effect if we don't find in the patient a strong ally. Another way of putting it is that healthcare today is a mass-cooperation exercise.

Viewing health through a manichaean prism of (non-)compliance, however, comes at a great cost. It stifles our sense of curiosity and care about the people and communities we serve and work with. Instead, assuming that we already know, we do not do the hard work of understanding them, their values, personal or cultural histories, motivations, and needs.

Without the intention to understand, people who we perceive to be non-compliant take on the shape of an obstacle.

This is part of the appeal behind big data, artificial intelligence, and nudging in healthcare. Defining public health problems with a mouse-click rather than having to engage with the complexities and contradictions of real human beings suits the impatient implementor. To algorithms, people who feel ashamed about their HIV diagnosis and therefore prefer not to take their pills or go to their appointments are equal to those who care for their health but still struggle with the time-consuming exercise of controlling systematically their eating and exercise habits – they are all non-compliers. Similarly, the popularity of nudges with policymakers in recent years has made most of the public communication on health a one-way street. Despite the advent of shared decision-making and

patient and public involvement in the NHS, too often the underlying question driving engagement is: how can I best convince you that I am right?

Covid-19: A Tale of Two Countries

This foreclosure to the possibility of learning from our patients and communities has undermined public trust and exposed its fragility in the current coronavirus pandemic. Working in a hospital in London's East End, I have experienced first-hand how we are failing (to reach) people from minority ethnic communities. There is now evidence that people from a BAME background have worse outcomes from COVID-19 pneumonia than the white British population (Public Health England, 2020; Apea et al, 2020). We have to go above and beyond to ensure that disadvantages which vary in nature from biological (e.g. high prevalence of diabetes in populations of South-Asian ancestry) to socio-economic (how daunting is it to make a 111 or 999 call for an frail, elderly person whose first language is not English) do not translate into worse disease outcomes [4,5].

Both nationally and locally, it took too long to get the key messages across. For my patients with South Asian roots, this needed more than translating "Stay Home, Save Lives" into Bengali, Punjabi, and Tamil. It would have required a deeper understanding of the realities of their lives and livelihoods, driven by genuine curiosity and care. Researchers and policy-makers have long spoken of so-called 'hard-to-reach communities' in relation to underrepresented groups. To me, this is a complacent term. It puts the onus on the service user rather than on building a foundation of trust necessary to engage them.

Amid a new drive towards big government programmes not seen since the Great Depression, it might be easy to miss the other tale that has formed part of the coronavirus response in our communities. Across neighbourhoods in the UK, over 4,000 mutual aid groups have spontaneously sprung up to support the most vulnerable – all without central coordination and not much more than a basic template. (https://covidmutualaid.org/) In the early days of lockdown in March, my partner helped setting up a local group.

"It all began by joining a WhatsApp group with more than a hundred people. We all wanted to make sure that, if the virus hit us hard, nobody would be stuck sick at home or too frail to carry shopping bags", he tells me. "The question was: how do we organise our area, its volunteers and those in need? And, in a way, the epiphany was that we don't."

Within a day, they had launched a GDPR-compliant survey to register volunteers and printed simple flyers asking for what people needed with the handwritten contact details of a local volunteer. "All that the temporary admin team did was ensure no streets were uncovered. And then we left it to mini-teams covering no more than a few streets. At no point was there a central coordination of requests. Instead, people forged new relationships with their immediate neighbours through non-transactional giving." All of this happened before the government started sending food packages to those shielding. As for the huge WhatsApp group, it is now primarily used to circulate a weekly menu of food deliveries from a blend of private supercooks, soup kitchens, and local business.

To those of us who have been fighting coronavirus on hospital wards, this is both an unbelievable and familiar story. Familiar because also in my hospital, suddenly things were very simple. After years of unsuccessful lobbying, paper notes and paper requests forms were scrapped and converted into their equivalent electronic form. Or, the incredibly laborious way of dividing new medical admissions between different teams was replaced by a simple, ward-based model of care. Unbelievable because as doctors we are endowed with a huge blindspot: we see people for whom things have gone wrong, after they have gone wrong. This means we do not often see people caring for themselves and others in the community. This feeds cynicism, and

in turn makes us less likely to see our patients as people whom we could learn from. Yet our own experience of leading our local wards and trust through trying times, taking charge, and making things work better for our patients should give us more trust in our patients' abilities to transform their lives.

Public service is always local

As part of a covid recovery strategy, we need to tap into both the intrinsic community spirit that mutual aid has demonstrated and the purposeful action of professionals through adopting new care models. One of them is the hard-to-pronounce Buurtzorg (Dutch for 'neighbourhood care'), through which self-managing teams of district nurses provide both medical and supportive home care services [6].

Buurztorg was launched in 2006 in the Netherlands to respond to challenges that sound all too familiar: fragmentation of care and a demoralised workforce. For founder Jos de Blok, the answer lay in self-management. At the core of this strategy is enabling people to manage their own lives as much as possible. Buurtzorg nurses actively rely on patients' capacities and motivations, as much as trying to bring in the informal networks including relatives, friends, and local charities around them [7]. But the idea of self-management also applies to the workforce. Nurses care together, as a team of up to twelve members, for a relatively small group of patients (maximum 60). Keeping the numbers low enables workers to make collective and/or autonomous decisions to solve matters. Each team only operates at the neighbourhood level, which empowered nurses to go beyond the mere nursing and medical management of their patients. Buurtzorg's nurses are more like "health coaches", who create sustainable solutions leading towards prevention and care independence [8]. Leveraging existing support systems, 'they are available round the clock and – working closely with GPs – they organise all the supporting care, drawing in families, friends, and volunteers. They see themselves as community-builders' [9].

The home care social enterprise, which now spans more than 850 teams, has risen up to the challenge in achieving consistently high patient and nurse satisfaction, lower staff turnover, reducing costly hospital stays [10]. What Buurtzorg illustrates is that healthcare works best if it stands on a foundation of trust and autonomy, empowering both patient and carer. To the professional empowered to do a whole job, the whole person matters [11].

Now, the UK is not the Netherlands. When I spoke to Martin Brendan, managing director of Buurtzorg Britain and Ireland, he openly admitted challenges of bringing the model to the UK. What some health leaders have misunderstood is that giving your frontline staff the tools to do their jobs is something very different to leaving them to their own devices to somehow prove that you didn't make a mistake by entrusting them with their tasks. "We've revealed great potential but you must start with clarity of purpose and strong leadership commitment, and create an enabling and supportive environment for practitioners to succeed with self-management," Martin told me.

This, to me, is a question of right engagement as a leader. While we should have national strategies to fight cancer, fund dementia research, and, yes, train and retain a world-class health workforce, public service is ultimately always local, drawing actively on communities rather than just seeing them as landscape. It would therefore also be wrong to simply call for the Buurtzorg model to be the blueprint for a health and social care reform.

Beginner's mind

In the 2020s, UK health policy does not merely need a new manifesto and spending promises, it needs an upgrade to its leadership philosophy. We do not first and foremost need 40 new hospitals in Britain, but self-caring neighbourhoods and well-

trained professionals in locally responsive public services, supporting healthy populations. To move to care beyond compliance then, we must also be prepared to say: what works in Wigan, might not be right in Reading. As Zen master Suzuki Roshi writes: "In the beginner's mind there are many possibilities, but in the expert's there are few."

Creating this future for healthcare thus begins with curiosity and care. This is why I believe the most powerful question that any minister of health, nay, any leader, can ask is: **how can I help?**

And then listen.

References

[1] Health Profile for England (2018) Trends in mortality. Public Health England 2018, Chapter 2. Available at: https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter- 2-trends-in-mortality.

[2] Elliott, R. (2013) 'Non-adherence to medicine: the scale of the problem'. Prescriber. Available at: https://wileymicrositebuilder.com/prescriber/wp-content/uploads/sites/23/2015/10/Non adherence-to-medicines-the-scale-of-the-problem.pdf

[3] Nicholson, B. D. et al. (2016) 'International variation in adherence to referral guidelines for suspected cancer: a secondary analysis of survey data'. *British Journal of General Practice*, 66 (643): e106-e113.

[4] Public Health England (2020) Disparities in the risk and outcomes from COVID-19. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

[5] Apea, V. J. et al. (2020) Ethnicity and outcomes in patients hospitalised with COVID-19 infection in East London: an observational cohort study. medRxiv 2020.06.10.20127621; doi:https://doi.org/10.1101/2020.06.10.20127621.

[6] Cirkovic, S. (2018) Buurtzorg: revolutionising home care in the Netherlands. Centre for Public Impact. Available at: https://www.centreforpublicimpact.org/case-study/buurtzorg-revolutionising-home-car e-netherlands/

[7] Buurtzorg International (2020) The Buurtzorg Model. Available at: https://www.buurtzorg.com/about-us/buurtzorgmodel/

[8] Brindle, D. (2017) 'Buurtzorg: the Dutch model of neighbourhood care that is going global'. *Guardian*, 9th May.

[9] Brimelow, A. (2013) 'Dutch district nurses rediscover 'complete care' role'. BBC News, 27 March.

[10] Kaloudis, H.(2020) A first attempt at a systematic overview of the public record in English on Buurtzorg Nederland (Part B — The Buurtzorg Organisational and Operational Model). Available at: https://medium.com/@Harri_Kaloudis/a-systematic-overview-of-the-literature-in-engl ish-on-buurtzorg-nederland-part-b-the-buurtzorg-189a7e4704b0

[11] Sheldon, T. (2017) 'Buurtzorg: the district nurses who want to be superfluous'. *British Medical Journal,* 358:j3140.

Paolo d'Arienzo

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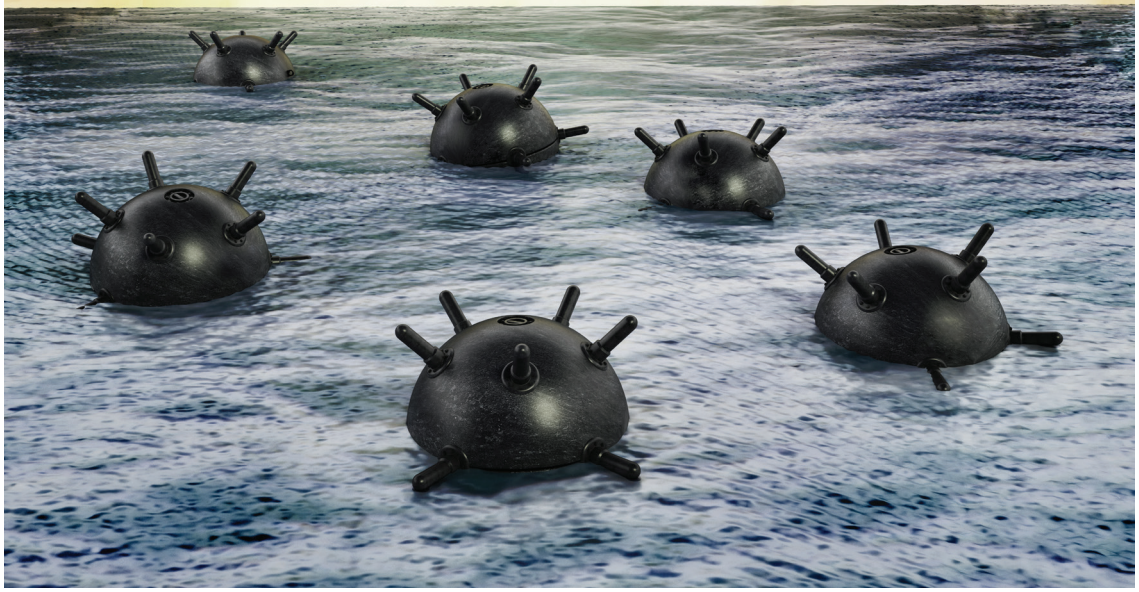

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