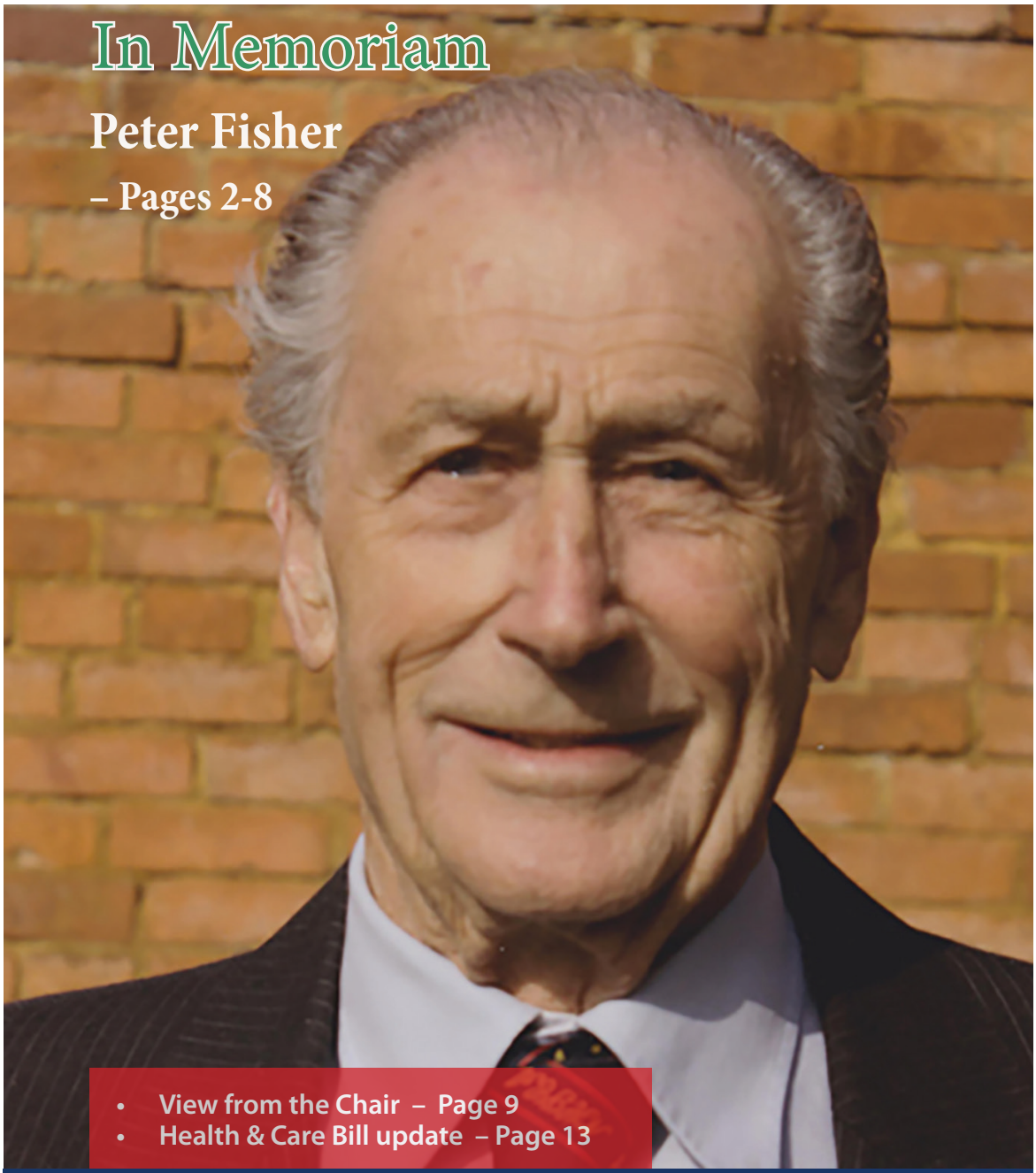
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

In Memoriam

Peter Fisher

– Pages 2-8



AUGUST – SEPTEMBER 2021

Peter Fisher

Colin Hutchinson, Chair:

It is with great sadness that we report that Peter Fisher, one of the founder members of the NHS Consultants Association in 1976, and President of DFNHS, died on 12th August 2021, at the age of 88, at home, with his family beside him. Our condolences go out to them.

I am very grateful to Roseanne Edwards, a friend and fellow campaigner with the Keep the Horton General group, with which Peter worked tirelessly, for allowing us to include the extensive obituary which was published in the *Banbury Guardian*, which includes many fascinating details of aspects of Peter's rich and active life of which few of us were aware (1).

Like many of us, my first contact with Peter came in the form of a letter, shortly after my appointment as a Consultant in Aberdeen in 1986, welcoming me to my new role and inviting me to join the NHS Consultants' Association. I think it is easy to forget that, when it was formed and for many years after, the NHS Consultants' Association was the only organisation campaigning to resist privatisation of the NHS. My wife always used to joke about how angry I would become after reading the latest edition of the newsletter, but it offered a rare dissenting, challenging, but constructive perspective, that often helped to make sense of what I was experiencing in my professional life and question why that should be.

Last year, Peter wrote a brief history of the organisation for the newsletter (2), which I recommend: it really does offer a long-term view of the association to which he devoted so much of his life and a sense of the forces ranged against the realisation of comprehensive, universally available healthcare. He embodied the description of a "medical activist". He was a powerful advocate, in words and deeds, of the importance of maintaining the clinical skills of a generalist and the place of district general hospitals in delivering comprehensive, accessible healthcare. He never gave up hope.

It was only when I had the opportunity to join the Executive Committee that I was able to appreciate Peter's qualities more fully. He was a very self-effacing man, seemingly more interested in hearing the other person's views than promoting his own, but somehow managing to reference the values and activities of DFNHS to anyone who might listen, right up until his final days. His wisdom, humanity and abundant common sense have been a tremendous source of support to me, and, I am certain, to many previous Chairs. I will sorely miss his guiding hand, particularly in these turbulent times.

We must preserve his legacy. Peter was adamant that we need to attract membership and active participation of doctors in the early stages of their careers and threw his presidential support behind the Annual Doctors for the NHS Essay Competition, which has attracted 79 entries this year, many of exceptional quality, from doctors in training, a number of whom have also joined as members. Our intention is that this should continue and it seems appropriate that we should formally link Peter Fisher's name with the prize for this competition. We will also be making a contribution to Peter's preferred charity, *Medecins Sans Frontieres*.

Eric Watts, former Chair:

I recall from the start, I think I joined NHSCA in the mid-1990s, that Peter worked tirelessly doing everything he could to promote the NHS and fought for it to stay true to its founding principles.

He would go anywhere and speak to anyone and I don't think he missed a single opportunity to be involved in local and national discussions and

fora to make the case for better care based on sound understanding of how medicine works and how the NHS delivers care and treatment.

He understood politics but was careful never to be partisan.

He noted that there were many Labour Party supporters in the Association and several other parties but he would always aim to reach a cross-party consensus in the proposals that he made. He was never blinded by empty political rhetoric and always based his opinions and comments on sound principles, firm evidence and wise analysis of decades of experience.

High profile consultants such as Harry Keen were included in the founding fathers of NHSCA: after they passed on, Peter took over much of the running of the Association including the donkey work of preparing and posting letters to (I think) every newly appointed consultant and would target the consultants and entire hospitals if there were issues in those places.

Once, a doctor from the Spanish Federation of Associations for Defending Public Health, with whom Peter had developed close professional ties, mentioned that he would be in the UK and could he take the liberty of meeting Peter in his office at NHSCA headquarters? Peters' reply was that he would be very welcome but the office might not be as prestigious as the visitor was hoping for. It was in fact the bedroom that his daughter had occupied before she left home. He never mentioned he had to move the typewriter and photocopier out if she came back to visit.

He was at the same time the engine room and the captain of the ship, always prepared to do the work for himself.

This included all the arrangements for the AGM including photocopying maps and location and sending them out with the tickets.

He was always there and always knew what was going on and was always pushing forward and I don't think he missed a single meeting until his advanced age and inevitable infirmity stopped him.

He has been the driving force and the mainstay of the continuity of the Association from 1976 until now.

Peter Trewby, Hon. Treasurer:

14 years ago in response to Peter's tireless emailing and letter writing I joined the NHS Consultants' Association (as it then was) and again in response to his gentle persuasive manner was inveigled to become Treasurer. Who could refuse?

One of the Treasurer's jobs was, and still is, to chase up miscreant members who do not pay their subscriptions. Peter's ethos was that it should be more difficult to leave DFNHS than to break into the Bank of England. Emails and letters from me would be followed by "Letters from the President" and if no response, 192.com- address-finder would be called into action. Peter also had a personal link with a firm that kept addresses of all NHS consultants and telephone calls would then follow to bewildered hospital secretaries. If still unsuccessful, the whole process would be repeated, sometimes often over a period of many months. Only if this all failed would a final pre-bereavement letter go out with a "final newsletter" stating that sadly unless they relented this would be their last communication from us. Only then, if no reply, were they deemed no longer worthy to be one of us and were "deleted". Such was Peter's devotion to *Doctors for the NHS*.

With Covid and lockdown he remained as active as ever, embracing Zoom technology and appearing by telephone at meetings often accompanied by his cat whose purring sometimes drowned out other participants. Still active to the end, at his last meeting, 3 weeks before his death, he spoke passionately about the need to address the workforce shortages in the NHS.

He worked tirelessly to campaign for the NHS as a publicly funded, publicly accountable and publicly provided service. He saw the artificial separation of the NHS into "providers" and "purchasers" as a complete anathema to the founding principles of the NHS. He saw the split as only serving to drain

money into NHS bureaucracy. He saw the NHS as the world's greatest ever example of a population agreeing to provide care for its sick, exemplifying to him the essence of civilised society. He was steadfast in his desire to preserve the ethos of the NHS.

At his funeral which I had the privilege of attending and in his obituary in the *Banbury Guardian* we learnt of his other work including spear-heading the campaign to keep his local hospital, Horton General Hospital, from being downgraded and of his work, before retirement, as a totally dedicated holistic General Physician and Gastroenterologist, the like of which sadly we no longer see. He was a devoted Christian and his belief shone through so much of what he did and, as a very able and practical man, he was self-appointed carpenter-in-residence to his local church. A man of so many talents.

He and his wife Veronica had a cottage in Carperby and it was a real delight to join them for a pint in the Bolton Arms at Downholme when he was staying there. Those days are sadly gone but his memory and ethos remain as strong as ever and will remain so. He will be so much missed by us all, both as our President and our friend.

Alan Taman
Communications Manager:

I can't add much to the moving and sincere eulogy to Peter given above. But I will add that Peter always showed great faith in me, as a professional and fellow campaigner. Fairly early on in my time with DFNHS (I was appointed in 2015) I remember feeling a little anxious about taking over production and distribution of this newsletter from Peter, a task he had done almost single handed for many years. He raised the matter at an Executive meeting and, in that wonderfully gentle and perceptive way of his, pointed out that he was only too glad to pass that particular mantle on.

I resolved then to do everything I could to make this newsletter, and DFNHS, count. His death has only strengthened that. To those who do not know me, I am not in the first flush of youth (I could have taken my state pension in a few months, were it not for successive governments moving the minimum age, in a Bismarckian feat of cynicism, ever further away). In my time, I have met many people who could be described as authorities in their field. Few have left me with an abiding sense of humility and inspiration, as Peter did.

It's often said, of a natural leader when they are gone, that those who believed in them, and what they stood for, will not forgot. What matters more, surely, is that those who follow when we are gone are not faced with a health service which no longer upholds the principles of the NHS when it was founded. A threat Peter saw only too well, and which DFNHS exists to fight. We shall keep fighting.

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[1] See page 6. The full obituary may be accessed via the *Banbury Guardian.* Edwards, R. (2021) 'Dr Peter Fisher, consultant physician, Banbury politician, defender of the NHS and 'untouchable' at the Horton General Hospital, has died aged 88', *Banbury Guardian*, 16 August.
Available at: https://bit.ly/2Xa0YRA
[2] Fisher, P. (2020) 'A brief Presidential history of our organisation', *Doctors for the NHS Newsletter,* July. Available at: https://bit.ly/3IhbSxn

Peter Fisher: Obituary

(Reproduced, with permission, from the *Banbury Guardian*, 16 August)

Dr Peter Fisher, Horton hospital consultant, politician and dedicated campaigner for Banbury's general hospital and the NHS, has died, aged 88.

His professional life was spent in the medical world and he was completely dedicated to the National Health Service. He spent nearly three decades as a consultant at the Horton where he was said to be 'untouchable'.

In 1976 he was a founder member of the NHS Consultants' Association (later re-named Doctors for the NHS) and continued campaigning up to 3 weeks prior to his death.

Dr Fisher was a founder member of Banbury Health Emergency, set up to defend and protect the Horton as a general hospital. The organisation was later renamed Keep the Horton General (KTHG) and Dr Fisher remained a member, recently contributing his considerable medical and strategic knowledge to a 2017 High Court case which challenged downgrading of maternity and closure of beds without proper public consultation.

His death, at home in Great Bourton on Wednesday, August 11, has prompted many tributes from people who universally described him as wise, humane, sensible, hard-working, kind, gentle and committed.

Peter Fisher was born in Northallerton, North Yorkshire, the only child of Jack and Nora Fisher. He won a scholarship to Northallerton Grammar School and went on to Cambridge University to read medicine. A talented athlete, he was invited to join the Alveston Club, specialising in long jump and high jump. He was a keen hiker, completing the Lyke Wake Walk in his 40s.

Dr Fisher went to Middlesex Hospital to do clinical studies. During that time he met Veronica – also a doctor – on a skiing holiday and the two married on August 2 1958. They celebrated 63 years of marriage earlier this month.

The couple had four children, Louise Dexter, Tom (a lawyer who died in 1995), Mary Burnett and Helen Fisher. They have one granddaughter, Macy, now 15 who is an exceptionally talented swimmer of whom Dr Fisher was very proud.

After Middlesex Dr Fisher became a houseman at Hemel Hempstead where he stayed for 18 months before moving to Cornwall for a year. In 1960 he and his wife went to Fiji and Western Samoa to join the South Pacific Health Service for 3 years as a medical officer.

Daughter Mary Burnett said: "They absolutely loved it and never stopped talking about it. Veronica qualified a year later than Peter and set up a GP practice there in a Catholic community hall. She was also medical officer for an Australian sugar refinery. In Western Samoa she was medical officer for the colonial service in obstetrics and gynaecology."

On their return Dr Fisher was appointed a medical registrar in Northallerton and then took up a post as a medical registrar in Liverpool where he stayed for 5 years. In 1969 the family moved to Banbury where Dr Fisher took up a position as Consultant Physician for Oxfordshire based at the Horton General Hospital but travelling to clinics around the county.

His wife, a GP, joined the Cropredy Surgery, moving to Hightown Surgery where she became senior partner after 9 months.

Mrs Burnett said:

"He was a hard taskmaster; he made sure he got what he wanted for his patients. He was well known among his colleagues for being very driven and proud of his short waiting list – he worked his staff hard to ensure patients benefited and there

Peter (left) addressing the inaugural meeting after re-launching NHSCA as Doctors for the NHS *in 2015. (Right, Eric Watts, Chair, 2014-17)*

was no inefficiency. The patient came first.

"We never had a Christmas Day without first going to see the patients in the hospital and he would be allocated a particular ward to carve the turkey for the patients. All the wards were painted and decorated. We would dress up to entertain the patients.

"We have so many fond family memories of dressing up with Dad as Goldilocks and we girls would be the three bears and our brother Tom was the bowl of porridge. Then we'd go back for our own Christmas Day, having dinner in the evening."

Mrs Burnett said her father was a very important figure in Great Bourton where the family has lived since 1969:

"He has lived here for 52 years and has done a lot for the community, being instrumental in getting a playground for the village and belonging to the gardening and music clubs. The village fetes were held in our garden.

"Dad was a really strong moral compass and led by example – a moral guide in his professional and political world but also for his family."

He was a Governor at Banbury School and a member of CND, going to Greenham Common with Louise, then aged 14, and linking arms with other campaigners around the nuclear weapons base.

Dr Fisher campaigned for Labour in the 1970s and was elected county councillor for the Labour Party in the 1980s serving for three terms. In 1981 he was the Labour representative on a visit to Buckingham Palace, taking his wife and 18-year-old daughter Louise with him as his guests.

In the 1990s he was a founder member of the

Banbury Health Emergency whose first chairman was Steve Thorp:

"My involvement with Peter started when were both representing Calthorpe for Labour at district and county level in the 1980s. What a good kind caring man he was – a really gentle man – also fiercely committed to the cause he was involved in. He was one of the stalwarts of the community and the Labour Party," said Mr Thorp.

"Because he worked at the Horton he was involved in Banbury Health Emergency with Sue Edgar and me and others. He was our main consultant who we used as an information-giver. He was highly intelligent, always willing to get information, to make sure we had the right contacts - he was an enabler. He'd be on the front line talking to the press and everyone else as well.

"He was vastly respected across the political and medical spectrum. He had that kind of authority within the Horton. He said what he wanted to say and was untouchable."

Peter Fisher retired in 1997 aged 65 but never gave up political campaigning. His work to protect the Horton continued with KTHG. One of the highlights of that campaign was winning a battle to prevent a full-scale downgrade of the hospital when Health Secretary Alan Johnson confirmed the Independent Reconfiguration Panel's view that Oxford was too far away for Banbury patients to travel for acute services.

KTHG member Jenny Jones said: "We joined KTHG after a rally in the People's Park, during that 2006-2008 campaign, followed by viewing a webcast of a council meeting where Peter was presenting the issue of loss of maternity and paediatrics on his own. He said that he had expected to be joined by other clinicians but no-one else had turned up. Nevertheless he forged ahead. We will miss his medical expertise but we will also miss his determination."

Keith Strangwood, chairman of KTHG said: "A life lived without caring about others is a life wasted and Peter spend almost all his life caring about others in some way or other. He was the voice of reason."

Sophie Hammond, KTHG maternity officer, said: "This is terribly sad; what a great loss. It isn't just his vital medical knowledge and experience we're going to miss. His clear-sighted, fair-mindedness and diplomacy were great assets to the campaign. He was the embodiment of 'If' by Rudyard Kipling. He will always be an inspiration to me."

Peter Trewby of *Doctors for the NHS* said: "I know from hearsay that he was an immensely hard-working Physician of the old style, taking a holistic approach to the patient.

"He was always passionate about the NHS and in 1976 was one of the founding members of the NHS Consultants' Association which in 2014 became Doctors for the NHS as it expanded to welcome all doctors.

"He was made Chair and subsequently President for life. He worked tirelessly to campaign for the NHS as a publicly funded, publicly accountable and publicly provided service. He saw the artificial separation of the NHS into 'providers' and 'purchasers' as a complete anathema to the founding principles of the NHS.

"He saw the split as only serving to drain money into NHS bureaucracy. He saw the NHS as the world's greatest ever example of a population agreeing to provide care for its sick, exemplifying to him the essence of civilised society.

"He was passionate in his desire to preserve the ethos of the NHS. He worked tirelessly to recruit members to the Association, writing to doctors throughout the United Kingdom from his office in

his daughter's bedroom.

"With Covid and lockdown he remained as active as ever, embracing Zoom technology and appearing at meetings often accompanied by his cat, whose purring sometimes drowned out other participants. Still active to the end, at his last meeting, 3 weeks before his death, he spoke passionately about the need to address the manpower shortages in the NHS," said Mr Trewby.

"His wisdom, humanity and abundant common sense were apparent in everything he did and were an inspiration to so many. *Doctors for the NHS* is proud to have had him as leader and exemplar over so many years. He will be much missed."

Dr Eric Watts, retired consultant and chair of NHSCA from 2014-2017 said:

"Peter Fisher and colleagues decided to form the National Health Consultants' Association in 1976 as they believed that the British Medical Association (BMA) was putting too much emphasis on private practice and not enough on building up the NHS and that there needed to be a doctors' organisation to champion the health service.

"Since that time the BMA position has changed. We will never know to what extent they may have felt the need to recognise that doctors committed to the NHS felt the need to set up a separate organisation.

"Peter Fisher engaged with many politicians; he and other committee members of NHSCA would often be invited to the House of Commons to present our views and evidence to MPs including secretaries of state. I recall meeting Frank Dobson and Alan Milburn.

"Peter was the ideal exemplar not only in respect of his skill in motivating and channeling the energies of people who shared his views but also in the amount of sheer hard graft that he put in himself.

"I recall him speaking of the work that he did writing to every newly qualified consultant for a period of time to advise them of our activities. He wrote to anyone who could help the cause; he spoke at local and national meetings and engaged with politicians tirelessly.

"I recall one anecdote relating to cooperation with doctors from other countries. A doctor from a prestigious medical organisation in Spain mentioned that he would be in the UK and could he take the liberty of meeting Peter in his office at NHSCA headquarters?

"Peters' reply was that he would be very welcome but the office might not be as prestigious as the visitor was hoping for. It was in fact the bedroom that his daughter vacated when she left home. He never mentioned if he had to move the typewriter, photocopier and assembled equipment out when she came back to visit.

"It was typical of the man that after he retired from clinical practice he decided that he should stand down as chairman as he felt it most important that the chair was actually a working consultant. Therefore we created the post of president, specifically to keep him in a leadership position.

"Those of us who have followed him as chair soon realised what an enormous challenge we are facing and the fact that he seemed to do it with effortless grace is another testament to his uniqueness."

A Requiem Mass was celebrated at the Catholic Church of St John the Evangelist, South Bar, Banbury, on Tuesday, August 24 followed by interment at Claydon Church.

Roseanne Edwards
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View From The Chair: September 2021

Although the daily prime ministerial briefings are now just a fond memory, there are far fewer discarded masks and gloves littering the streets, the mice are being driven back onto their wheels and days go by without a mention of C**19 in the evening news, quite a few people retain a lingering sense of unease.**

The patches of blue, purple and black spread across the interactive map of the UK on the Government website (1), like a maturing bruise. The curves on the graphs of hospital admissions and deaths creep stubbornly upwards, but we seem to have ceased to think that more than 900 people dying from a disease unknown 2 years ago is cause for concern. There is no denying the achievement in vaccinating 80% of the population above the age of 16 years, but should we really be abandoning all the other measures that could supplement the protection afforded by the vaccines at so little cost to our comfort and quality of life? We were initially told we would have to learn to live with Covid: now we are simply being told that we have to live with it – the learning has gone out of the window. We will learn soon enough whether we have been right to put all our eggs in the vaccination basket.

Have we learned anything?

What is clear is that people have short memories, and politicians' memories are shorter than most. The revelation that our society would disintegrate without the contribution of the "essential workers" – often amongst the least well paid – does not seem to have produced a change in attitude. Much like the mayor of Hamelin Town, once the rats have disappeared, the honouring of debts becomes a low priority. But, as in Browning's poem, failure to take appropriate action at the right time can have terrible consequences.

Gaps on supermarket shelves; chicken restaurants running out of chicken; pubs with no beer; waste bins uncollected; a nation's health service running out of blood test bottles; an unscheduled delay to seasonal flu vaccinations when a more severe flu season is anticipated. The common thread? A national shortage of heavy goods vehicle drivers. A group of essential workers vital to maintaining our way of life, but not so vital, apparently, as to be deserving of decent pay and conditions (2).

Care workers, celebrated as heroes, working long hours under dire conditions at the eye of the storm of the pandemic, rarely paid the Real Living Wage, are being denied any prospect of significant improvement in their conditions of employment by continued squeezing of council funding and condemned to wait for a mythical White Paper before any prospect of the dignity that would come from training-backed career development and a proper career structure. The recent announcement of implementation of the delayed Section 15 of the Care Act 2014 will not "fix the broken care system, once and for all."

The deadline for mandatory full vaccination of care workers in residential homes for the elderly comes into force on 11 November and there is huge uncertainty as to how many of these essential workers will leave to take up other, potentially better-paid, work, with more social hours (3). It is not as if there weren't severe recruitment difficulties already. Might this not have been a good time to have brought forward a full package of measures to professionalise the people who care

after our most vulnerable members of society and make it possible for all local authorities to meet the standards of the Ethical Care Charter (4)?

Making sure things don't work

And as the echoes of the doorstep clapping become a faint memory and the crayoned rainbows fade, is the politicians' embrace of the NHS and its staff still one of love, or has it returned to the grip of a hungry python on a pet hamster (5)?

Maybe it's worth remembering the quotation attributed to Noam Chomsky, "That's the standard technique of privatization: defund, make sure things don't work, people get angry, you hand it over to private capital". The Government's expectation that the NHS can bounce back to providing prompt treatment for everybody, just because August 16 was declared Freedom Day, ignores several important facts.

Firstly, a lot of people are still becoming seriously ill from Covid, plenty needing intensive care and many are, sadly, dying. In my local hospital, nearly 10% of available beds are currently occupied by patients with Covid-19 and half the intensive care beds. This has a severe impact on the capacity of the hospital to return to its previous level of activity in treating non-Covid disease.

Secondly, even before the pandemic, the NHS was unable to meet the demand for its services (6): the 18 week referral to treatment target had been abandoned; the 4-hour target for A&E had been abandoned and the number of people on waiting lists was the highest since 2007. Shortages of clinical staff across the board and in many specialties was the key reason, due to reducing levels of funding for training and employing staff: inadequate staffing in turn caused deteriorating working conditions prompting yet more staff to retire early or reduce their hours of work. Reductions to hospital beds and lack of availability of diagnostic facilities and operating theatres added to the cocktail. None of these factors have been addressed effectively and no credible plans are in place to do so any time soon.

Thirdly, the delay to so much elective and diagnostic work was on the direct order of NHS England, but they are invisible to the public, who only see the underused hospitals and health centres.There was neither the staffing capacity nor the physical space nor the diagnostic equipment to simultaneously manage the direct impact of Covid-19 disease as well as the regular workload. Infection control procedures increased the time required for many procedures, further reducing capacity.

The promise of funding for 40 new hospitals might have been described by Edmund Blackadder as "a lie of sorts" when the details are explored (7) and the revelations about the manipulation of these stories being orchestrated at the highest level of NHS England smacks of "alternative facts" (8). Why does the duty of candour only apply to clinicians? Surely it is widespread knowledge that the 40 new hospitals comprise six large scale hospital developments and an additional 34 smaller projects. Isn't that good news enough, without the need for hyperbole? Except that the funding for the six large projects is now being squeezed and the two new blocks at Leeds General Infirmary, which are costed at £600 M, are now being asked to come back with revised plans that don't exceed £400 M. Still the likelihood is that people will still remember "40 new hospitals," even if they can't actually locate them.

People get angry

Primary Care, and General Practitioners in particular, are coming under sustained attack at present and receiving little obvious support from NHS England. Many of the reports in the media are about patients unable to access Primary Care, while the response from the BMA, Local Medical Committees and GPs themselves are that they are providing more consultations than ever before and their activity figures support this (9). Is it possible

that both could be right?

Primary Care has received particularly poor levels of investment for a sustained period, particularly since 2010. It has suffered from severe problems of recruitment and retention of GPs, with reports of low levels of job satisfaction, possibly exacerbated by changes in working practices, with less opportunity to provide continuity of care. Primary care was largely cut out of the loop in the early phases of the pandemic, with patients encouraged to contact NHS 111, rather than their health centre; no timely reporting of PCR test results to be interpreted in context with patients' other conditions; and even the lists of people being advised to shield themselves were compiled centrally and often erroneously.

Later, Primary Care was called upon to play a major part in organising and delivering the vaccination programme, and succeeded beyond expectation; a fact that seems to get conveniently forgotten amongst the criticisms. NHS England issued directives as to how to reduce contact with patients through total triage and a default to remote consultation. Some practice premises lent themselves better to adaptation for safer conditions for face-to-face consultation than others, but there are suggestions that there might have been some variability in the enthusiasm with which different practices approached the challenge (see discussion by John Hussey and Kathryn Moore in the October 2020 newsletter as to what can be achieved (10)).

Each practice has its own individual character, which is why it was felt to be so fundamental to the NHS that patients could choose their doctor. In my role as an elected Councillor, I receive feedback from many residents about their experiences and there is considerable variation between practices regarding the ease of access through phone systems – insufficient phone lines; being told you are held in a queue, but with no indication of your position in the queue; being on hold for 40 minutes or more. Many practices have websites that are poorly designed and do not give clear instructions as to how to go about booking an appointment. When you find a front page detailing special instructions if you have recently arrived from China, you know that it has not been updated for at least 18 months. If remote access and triage is the default position, it is vital that the telephone and online portals are clear and welcoming and build the confidence of patients. It's important that practices look at these points of entry from the patient's perspective, rather than from the practice's end of the line, otherwise complaints are inevitable.

Even before the pandemic, there was relentless pressure being applied from NHS England for a much greater use of remote consultation and the pandemic response has provided a huge stimulus to this process. Hopefully the experience that is being gained will lead to a nuanced approach, with a better understanding of when to consult remotely and when face to face. Reports of many more cancer referrals occurring at a later stage than previously is a cause for concern, and nationally we did not have a good track record of early diagnosis before the pandemic. The senior coroner for Greater Manchester has raised concerns over the possible role of remote consultation in five recent deaths (11), which should give some of the zealots pause for thought.

There seems to have been a degree of unwillingness to acknowledge the possibility that some patients might not be receiving the care they need, despite the great majority of GPs working as hard as they can, in a chronically under-resourced system. It is important that we listen carefully to what our patients are saying, diagnose where things are going wrong and draw up a plan to fix it – just the same as we do in any consultation. We are all on the same side, after all.

Hand it over to private capital

There are concerns that expectations are being raised unrealistically of the time that it will take to achieve some kind of normality. Substantial

additional funding is being promised for 3 years, but it is unclear how much of this might be available to invest in building up the capacity of the NHS. Those of a suspicious disposition might worry that much of this funding might end up in the hands of the independent sector with portrayal of private hospitals as coming to the rescue of a struggling NHS, while ignoring the fact that it is largely the same doctors, largely trained at public expense, working in both sectors, rather than real additional capacity. We need this money to be used for the benefit of all patients now and in the future, which is why DFNHS is backing the latest campaign and petition run by We Own It (12). As described elsewhere in this newsletter, the Health and Care Bill could lead to much greater blurring of the boundaries between public and private healthcare; the very situation that prompted the NHS Consultants' Association to be formed in 1976.

Stories of desperate patients, facing indefinite waits for treatment, deciding to pay for private treatment are appearing in the media with greater frequency and run the risk of further undermining the support for the NHS and the expectation that it will be there for us all in our hour of need.

We need to make every effort to ensure it will be.

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The Health and Care Bill: Update

The Health and Care Bill, which sets out the next large scale, top-down reorganisation of the NHS in England, is being fast-tracked through Parliament, to meet its self-imposed deadline of implementation by 1 April 2022 (1). Organisational changes are already happening on the ground on the assumption that the Bill will be enacted with few substantial changes.

Why such a hurry? Is the Bill going to begin to tackle the massive shortage of clinical staff and the haemorrhaging of experienced clinicians from the service? Is the Bill going to magic up the resources to deal with the huge backlog of non-Covid care that has been put on hold? Is it going to provide sustainable and fair funding for social care and those who deliver those vital services? Or is the Bill going to rebuild the public health services that have been run down under the twin cosh of austerity policies and previous reorganisations? I don't think so.

Integration through fragmentation?

Under the guise of "integration", it actually breaks the NHS up into 42 separate health and social care systems, governed by their own constitutions, with considerable discretion as to what services they provide, and what they don't (Clause 18). Each Integrated Care System (ICS) will be subject to stringent financial control systems, to ensure that it keeps within its allocated budget, which is likely to drive the continuing reduction of services, the centralisation of the sites from which they are delivered, and the dilution of the expertise of the staff delivering care. We have seen how such devolution has promoted increasing divergence between the health services of the four nations of the UK. The proposals in this Bill run the risk of taking us further and further away from the concept of a National Health Service and increasing the stakes in the postcode lottery in access to care.

Service, not profit

Each ICS would comprise an Integrated Care Board, and a wider Integrated Care Partnership. The Board will be directly accountable for NHS spending and the performance of the system. The Partnership will be made up of a wider group of organisations and be responsible for developing a strategy to address the health, social care and public health needs of the population for which the ICS has "core responsibility."

It is anticipated that the Board will establish subcommittees at "place" level, where much of the work of the Board will take place. "Place" is not defined, but has been assumed to correspond with a local authority's boundaries in most instances and it is possible that these subcommittees may bear some resemblance to the current Health and Wellbeing Boards.

Although the Bill sets out the members that have to be included in the Board, additional members can be appointed at the discretion of the Board and the membership of the Partnership is similarly and intentionally left open to local decision. This leaves it entirely possible that private, for-profit organisations, could become members of either the Board or Partnership and be in a position to influence the development of services to meet their preferred business model and secure a commercial advantage. This is even more of a risk because the Partnership, within which such decisions is taken, is not a statutory body and is under no obligation to publish agenda or minutes, or hold meetings in public. Removal of contracting for clinical services from the scope of Public Contract Regulations 2015, opens the way for highly valuable long-term contracts to be awarded without an open tendering process (Clause

68), the risks of which have become evident in contracting for the National Test and Trace Service and personal protective equipment, as noted by the National Audit Office (2) and the Commons Public Accounts Committee (3) and continuing revelations resulting from the actions of the Good Law Project (4).

The Seven Principles of Public Life, often known as the Nolan Principles, were drawn up in 1995, in response to concerns about the probity of parliamentarians, sparked particularly by the cash-for-questions scandal (5). The first of these principles, selflessness, is that holders of public office should act solely in terms of the public interest. Other principles include being accountable, including submitting to scrutiny if necessary, and acting in an open and transparent manner. However, one of the key legal duties of company directors is to "act in a way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole." It is difficult to see how these could be reconciled if commercial organisations find themselves as voting members of the Board, any of its subcommittees, or the Partnership. The governance arrangements in the Bill are far too vague to inspire confidence (Clause 14Z30).

The value of professional standards

Most clinicians' activities are subject to professional regulatory bodies, with the express aim of protecting the public. These regulatory bodies, including the General Medical Council and the Nursing and Midwifery Council, are governed by act of Parliament and that can only be changed by another act of Parliament. This Bill would allow the Secretary of State to abolish any of these bodies, if they so wished, without new legislation. Why are these new powers being sought? The most likely reason is to make it easier to substitute clinicians trained to a defined standard, and governed by professional standards, with less qualified staff, working in a flexible and 'agile' manner. The shambolic state of current workforce planning might be disguised by such moves to recruit non-regulated staff, who might coincidentally be cheaper, but at what cost to the quality of patient care?

There is a touching faith in the ability of algorithms and artificial intelligence to maintain public safety despite the weakening of professional regulation, but this ignores entirely the high level of skill required to take a full clinical history, assess its reliability and the overall context of the patient's life, and apply a weighting to the symptoms elicited. It ignores the skills in performing an appropriately thorough clinical examination.

"There is a touching faith in the ability of algorithms and artificial intelligence to maintain public safety despite the weakening of professional regulation"

The index of clinical suspicion is something that only develops with experience and continuing education. I feel like screaming whenever I hear a manager say that the patient should only have to tell their story once: the story often changes each time they tell it, depending who is taking the history, with important elements only being revealed under gentle inquiry. They may have been prescribed a particular medication, but are they actually taking it as prescribed? All artificial intelligence suffers the same weakness – garbage in equals garbage out.

After the computer has delivered its verdict, there is further clinical skill required to assess whether it makes sense, and whether it is appropriate as part of the holistic care of the patient. And yet further skill in explaining the situation to the patient and gaining their trust in carrying out the plan of

treatment. It is disappointing that the Academy of the Medical Royal Colleges do not comment on this aspect of the Bill (6). Professional regulation is there for a very good reason and the threshold for deregulation needs to very high. Surely it is not too much to expect the case to be made before Parliament and be subject to informed scrutiny? Surely the way to address the workforce shortage is to train sufficient clinicians and make sure their jobs are professional satisfying, so that they stay in those professions?

No time to lose

The main purpose of *Doctors for the NHS*, from its origin as the NHS Consultants' Association, was to prevent the subversion of the founding principles of the NHS by the pursuit of profit. This Bill, whether intentionally or not, would bring the English NHS into much closer alignment with the model familiar to citizens of the United States. Many amendments have already been put forward to try and prevent that possibility (7). Members of *Doctors for the NHS* need to do their utmost, including speaking to their MPs, to make sure those amendments succeed. The BMA has spoken out strongly, that "This is the wrong bill, at the wrong time" and will not address the most pressing issues facing the NHS, particularly workforce shortages (8). By contrast, the various royal colleges have generally been supportive of the proposed changes. Have they canvassed their membership? Why not let your college know your views? We must do our best to ensure our parliamentary representatives understand the substance and implications of the legislation they are voting upon, unlike their apparent approach to the Health and Social Care Act 2012 (9). *Keep Our NHS Public* and other campaigning organisations are mounting a vigorous opposition to the Bill: consider lending them your support (10). Time is short as the Committee Stage is unlikely to last much beyond the end of October.

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‘If I were Minister of Health’: More on Democratising Healthcare

A further selection of the entries from last year’s Essay Prize as a sign of the quality we can expect. Seventy nine entries have been received this year (some from overseas). We are re-naming the prize the Peter Fisher Essay Prize, in Peter’s memory, for future years.

Even before the coronavirus pandemic, other than being Prime Minister, the role of Minister of Health was probably the most daunting in Government. Considering the NHS regularly tops lists of most treasured British institutions, expectations of the Health Secretary may even be higher.

Given the problems in the healthcare system over the last decade, it is an unenviable position to inherit, but vast improvement can occur, we need only look at the revolutionary 1948 foundation of the NHS itself.

Improvement is usually best identified and implemented by those in the system, thus, it makes sense to have a Health Minister with field experience. Having worked as a NHS doctor for the past 8 years and as an occasional patient for two decades before that, I offer qualified insights into developing the health service.

First off, let’s deal with the barrier to productive discussion: money. There is money to spend. The UK has one of the strongest economies in the world, if that doesn’t equate to public spending power then I don’t know what use there is for a high GDP. Even if the piggy bank runs short following rainy day expenditures like the coronavirus furlough scheme then the solution lies in making large multinational companies pay adequate taxes by reforming corporation tax law (for example, Amazon paid just £220m in tax on UK sales of £10.9bn in 2018). The point is, money is available, let’s not use that as an excuse to limit progress.

Now we’ve redressed our outlook, we can approach issues in the healthcare service uninhibited by a fiscal fallacy. So where to start? How do you begin trying to improve such a gargantuan system? For ease of discussion I have focused on three key areas. Handily titled ‘People, Places and Public Health’ (forgive the alliteration but it’s the hallmark of any fledgling manifesto) I shall address these sequentially but consider all three to be of profound importance in improving the health service.

People

When asked to consider the biggest limitation of the health service, a plethora of headlines crowd for attention. Are the longer wait times in A&E more pressing or are the notoriously large waiting lists for elective operations the biggest issue? In actual fact, these are all facets of the same problem, namely that of insufficiency. There are not enough resources to meet demand and that translates to longer waits, compromised care and poorer health outcomes. And out of all the resources needed for a functional healthcare system, the most important is staff.

When we talk of a “lack of beds,” we actually mean a “lack of staff.” A hospital can bulk buy beds enough to fill every empty room in the building, but without a concomitant reinforcement of staffing (and that means all healthcare professionals, from cleaner to consultant) expanding numbers of medical equipment is essentially futile. Patients need CT scans and antibiotics, yes, but all these

interventions are facilitated by staff, for example, the porter to transfer a patient to radiology and the nurse to set up an IV.

Unfortunately for the NHS, staff are leaving in droves. From Brexit to burnout, the causes for people leaving are myriad. Each reason should be addressed individually, however, an easier way to summarise the problem is that on balance, for many the pros of the job no longer outweigh the cons.

Over the past few years austerity-driven cutbacks have made conditions in the NHS extremely difficult. Experiencing insufficiency as a daily reality wears people down. Not only that but healthcare workers are regularly denigrated in the press and undermined by the Government with both entities scapegoating healthcare workers (or Moet Medics as some of us are known) for deficiencies in the system.

But let bygones be bygones. How do we stop the attrition of the workforce? No, let's go one better – how do actively recruit people to the health service? Coronavirus has shown that by increasing the standing of the healthcare worker more people are attracted to the field. Since the pandemic hit applications to study nursing at university have increased by 15%, which is no doubt fuelled by the heroic portrayal of nurses in the news. However, it is not just through the media that standing improves, the whole healthcare profession must be made more attractive.

For this we look at Google. Why do so many people want to work there? The lucrative salary plays a part but NHS workers would likely settle for more conservative wages. An inflation-matching pay rise is a good starting point but if the Department of Health were to go one better and make salaried positions handsomely paid it might draw workers away from more costly locum work. Recruiting a regular workforce would make for reliable staffing levels and thus, safer care.

We can aspire to even more than that. The NHS could become a truly tempting employer by rewarding its employees benefits like free meals, free parking and free gym membership as swanky private companies do. And why not provide heavily subsidised childcare at Trusts for all employees? A large clientele already exists, the only thing needed now is to develop the infrastructure. The NHS could then truly practise what it preaches by improving the well-being of staff as well as patients.

Finally the system should place great emphasis on nurturing staff potential. Study budget and study days should be easier to access and professional development should be encouraged and facilitated. This ties in with the second prong of my plan as Health Secretary: structural organisational change in the places we work in.

Places

Healthcare is demanding. It is labour intensive and can be emotionally draining but it needn't be hard. By that, I mean the essence of healthcare can be deconstructed to a fairly simple model (Fig. 1).

But as many of us working in the system know, it can feel incredibly hard. The Fig. 1 process is sludged up by lack of flow through the system, which is down to the aforementioned insufficiencies. These insufficiencies are partly due to Trusts trying to reduce budget deficits by cutting costs and in so doing, reducing services, where they can. The other tactic employed is to erect boundaries (often prodigious bureaucracy) to stall people when applying for services. Paperwork also burdens clinical staff, who often have to produce exhaustive written evidence of the work they have done.

So what I propose is an overhaul in the approach. Firstly, we stop penalising Trusts. Anyone who has been in debt knows that you cannot make good decisions when you are financially stressed and this is backed up by psychological research. The "scarcity mentality" has been well documented in Mullainathan & Shafir's key psychological experiments, which show poverty can lead to a drop in IQ, ergo poorer decision making skills (1). To ameliorate this effect in healthcare we must eradicate deficits (remember, Amazon could

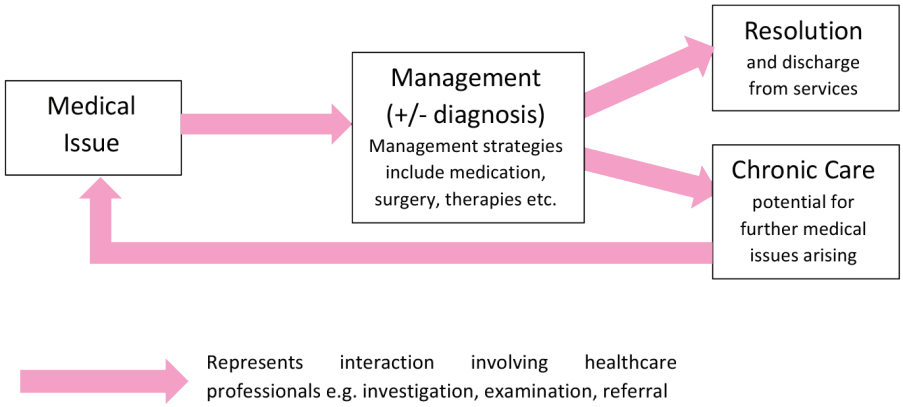

Figure 1. Flow diagram showing simplified healthcare process.

make up the shortfall) and instead of fining poorly performing Trusts, provide more money to tackle problems.

Improvement initiatives should heavily involve care workers themselves as their intimate knowledge of the system means they often know how best to solve a problem. Hands-off management has been shown to provide better services, for example, in the Netherlands the Buurtzog care initiative allows individual teams to decide how deliver care rather than by having far-removed managers dictate the approach. Analysis reveals that Buurtzog boasts higher quality social care for less cost than the average (2).

Also important in the approach is eliminating redundant layers of bureaucracy. Do Trusts really need a stratum of admin staff to double check every worker has done their e-learning? If that is necessary, could these staff not be redeployed to offer on-the-job training, thereby increasing administrators' experience of the system they are managing and minimising the paperwork burden on healthcare workers. Caregivers should spend as many hours actually caregiving rather than completing documentation to "prove" themselves. We must trust that healthcare workers, who for the large part went into this profession to help people, are doing their job. An errant employee usually becomes apparent in a team and can be reformed individually.

With more effective internal processes Trusts can broaden their vision to upgrading their physical places of work as well. That means bringing healthcare facilities into the 21st century by switching to renewable energy, rejigging waste disposal schemes to incorporate as much recycling as possible and buying local foods for the canteen. A healthcare system should embody the best values and always be on the right side of history.

Public health

The final part of my plan involves public health. The current health system has mastered the Fig. 1 process with a tiered approach (primary, secondary care etc.), albeit hindered by the problems listed above. The NHS knows exactly how to investigate chest pain, however, processes for keeping people well enough to stay out of the healthcare system are less refined. Public health is a relatively virgin

field and has great potential.

First off, we need all hands on deck and that means incorporating with social services. So much of healthcare is determined by effective social care and vice versa, the two organisations are really two heads of the same Hydra. That means the social workers and healthcare professionals should be working in the same team as par for the course rather than by occasional referral to each other.

A key limiting factor in hospital discharge of the ageing population is community care provision. We need a wholescale expansion of care, multiplying the number of facilities from nursing homes to rehab/respite centres to hospices. Concomitantly more care staff should be employed and similar to NHS workers, the profile of carers should be raised. As the coronavirus pandemic shows, this is truly essential work and should be esteemed as such.

With robust care infrastructure in place we can concentrate on promoting public health. This starts with adequate provision of the known basics e.g. addiction and smoking services, which over recent years have actually been reduced by a third amongst councils. Of course, keep existing programmes in place, we should keep promoting good diabetic control and immunising babies, but I also propose a stronger focus on wellbeing.

Hear me out, I know the idea of wellbeing has become a cliché but I am talking about more than superfood smoothies. Wellbeing forms the first tenet in the WHO's Constitution and is pivotal to the concept of health. It informs personal perspectives and can be the deciding factor on whether a disease becomes an illness. Thus, we should be doing all we can to promote wellbeing in every citizen.

This starts with combatting impediments to wellbeing e.g. loneliness, inactivity, mental health and of course, poverty. These are huge topics and would need specific targeting, however, key strategies for the former rely on strengthening communities. Alongside housing the homeless, multigenerational initiatives e.g. beautiful community centres and providing free NHS gyms would improve our communities immensely. I also propose heavily subsidised health holidays for all families, thereby fostering an interest in outdoor exercise in the next generation.

Mental health is a huge topic and in addition to its improvement through the "People" and "Places" part of this plan, additional attention should be given to psychology services. In my opinion, counselling centres should become as commonplace as the high street optician, recognising the fact that a lot of health issues are worsened by past trauma and underdeveloped coping mechanisms.

As to poverty, I need another 2000 words for that.

Summary

So there you have it, my proto-vision as Minister of Health. The ideas may sound simplistic, especially when condensed into a three point plan, but sometimes problems have to be simplified in order to deal with them. The health service is undoubtedly complex but the aspirations are easy enough to visualise and strive for: to optimise the health of every citizen in the most effective way possible. We must not let imagined impediments limit our vision. We can do better so let's begin.

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