DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

AGM & Conference 2021

OCTOBER – NOVEMBER 2021

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A View From The Chair

This edition of the Newsletter carries fairly full accounts of the Annual Conference of DFNHS, held in York, on 2nd October.

I make no apologies for this: we had the fortune to hear some informative presentations from inspiring speakers and the disruption of the last 18 months understandably resulted in hesitancy to meet up in person. Some members may be worried that we are showing signs of mission creep, with lectures on social care and public health. I would suggest that this is a very healthy development, similar to the change from the NHS Consultants Association to become Doctors for the NHS, in recognition that the desire for an NHS based on the highest professional standards, rather than commercial interests, is shared by colleagues at all stages of their career and across the range of disciplines.

Few of us can have failed to consider how different our response to the pandemic might have been if our system of public health had not been so weakened over the past decades, as described by John Ashton. At the same time, John Wright's inspirational presentation of the work being carried out to understand better the complex interaction of factors underlying non-communicable diseases, and the large-scale involvement of local communities under the Born in Bradford study, gives real grounds for optimism. Nigel Crisp, former Chief Executive of the NHS in England, titled his 2020 book, "Health is made at home: hospitals are for repairs", and the work from Bradford emphasises the need for changes in housing, town planning, transport and access for all to green spaces and healthy food, through cultural and legislative reform – the NHS is only one part of the picture. It should come as little surprise that the most recent outing for the DFNHS banner was at the Leeds Climate Change Demonstration, reflecting the threat that climate change poses to health and the shared roots of health inequalities, the commercialisation of health services and the over-exploitation of the world's natural resources.

Similarly, the artificial distinction between healthcare and social care should be a cause for concern for all doctors, both because of the inherent gross unfairness of the resulting system of social care, but also because the impact of a poorly resourced social care system on the ability to deliver healthcare. In my local hospital 100 of the 800 beds are occupied by patients waiting for suitable accommodation in social care settings. The same is true across the country, limiting the flow of patients from accident and emergency onto the wards, and requiring ambulance crews to deal with patients in the hospital car park, rather than attending urgent calls for assistance. Of course, the relentless drive to cut hospital beds has not helped.

Meanwhile, the Health and Care Bill continues its passage through Parliament, largely unamended, despite a range of amendments being tabled that might have reduced the opportunities for commercial organisations to be able to design healthcare to match their preferred business model and maximise their profits. I recently had the opportunity to meet Justin Madders MP, who sits on the Public Bill Committee, to discuss areas of particular concern to members and how they might be addressed, but the Bill is about to enter its Report stage, before passing to the House of Lords for further scrutiny, with possible further opportunities for its amendment.

I would like to encourage all members who share the misgivings described in the August/September Newsletter, to try and establish a dialogue with their MPs and try and help them understand the key areas of concern. Parliamentary arithmetic means that changes are only possible if some Conservative MPs can be persuaded to vote

against this legislation.

The Bill covers a hotch-potch of measures and in the light of this, it is interesting to note the comments of some of our speakers.

David Oliver offers the long perspective, that the various legislative changes introduced during his professional life have never been as dire as the critics fear, nor have the benefits been anywhere near as great as the advocates suggest. John Wright hopes that Integrated Care Systems may offer a route to changing local government policies and decisions in favour of creating healthier places for people to live and raise families. Personally, I respect their views, but still feel that the potential risks strongly outweigh the potential benefits.

At our Annual General Meeting, members supported the renaming of the annual essay prize as the Peter Fisher Essay Prize, in memory of the enormous contribution our late President made to this association. The winner of this year's competition is Catherine Huang and the runner-up is Celina Handalage and we offer them our sincere congratulations. Their essays will be published in a future issue. There were many outstanding entries, showing a lot of original thought and demonstrating the high levels of compassion, professionalism and commitment within so many doctors in training. As David Oliver remarks, the quality and enthusiasm of the next generation of doctors should be our main source of optimism for the future of the NHS.

Nevertheless, widespread concerns that the NHS faces its most difficult winter ever are based on a toxic combination of a shattered, demoralised and exhausted workforce, with no evidence of workforce planning in site, continued lack of capital investment in backlog maintenance of buildings and equipment, a crisis in primary care and many other factors described in David Oliver's lecture. The preference of the current government to channel resources towards the private sector wherever possible starves the NHS of the long term investment it so desperately needs. We can anticipate a broad campaign this winter, to demand decisive action to restore the NHS to a position where it can meet the challenge of providing universal comprehensive healthcare. DFNHS is affiliated to Keep Our NHS Public and to Health Campaigns Together and aims to be part of this campaign. Please explore links with campaigning groups in your area – your experience and support will strengthen and bring confidence to their voices.

In the meantime, I wish you all a happy and peaceful Christmas.

Colin Hutchinson
Editor and Chair, DFNHS
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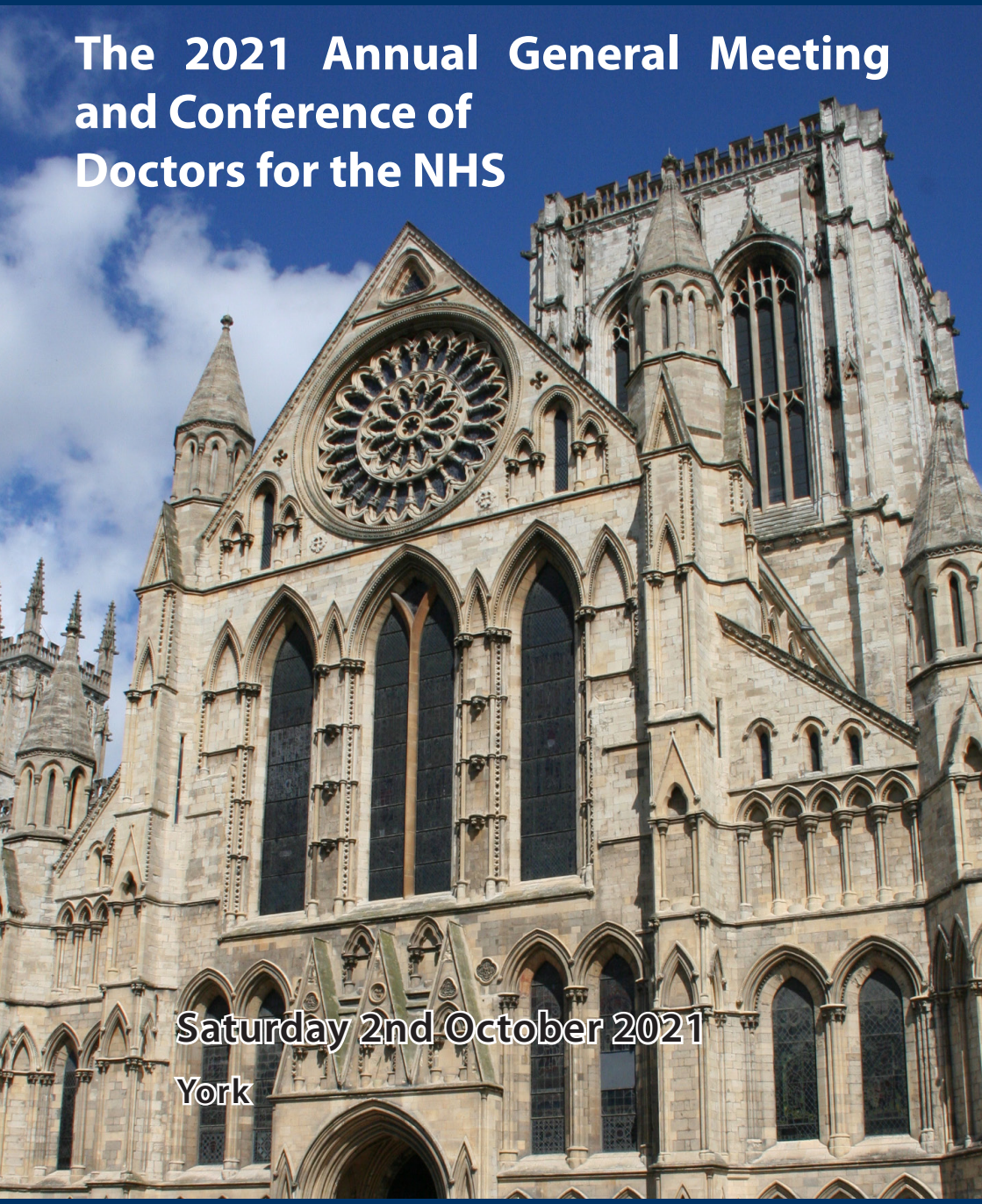
The 2021 Annual General Meeting and Conference of Doctors for the NHS



Saturday 2nd October 2021

York

AGM Reports

Opening address: Colin Hutchinson, Chair

[All of the Officers' reports can be downloaded from https://bit.ly/3DUM82b]

It is with great sadness that I have to report the recent death of our President, Peter Fisher.

Peter had been involved with DFNHS from its origin as the NHS Consultants Association, in 1976 and has been a point of constancy in the shifting landscape of the relationship between our profession and the NHS for over 45 years. He rarely missed a meeting of the Executive Committee and could always be relied upon for sound, principled, practical advice. His passing is a serious loss to our movement, but there has been much to celebrate in his life.

Peter had been an ardent supporter of the DFNHS Essay Prize Competition that is completing its fourth cycle - two years in collaboration with the *BMJ* and two with the *Journal of the Royal Society of Medicine*. The intention of the competition was to encourage doctors in training to think more widely about their part in promoting a healthy society, within the NHS. Under the inspiring leadership of our Treasurer, Peter Trewby, the competition has gone from strength to strength, with 79 entries this year including many of exceptional quality, demonstrating the depth of human qualities and wisdom in the upcoming generation of doctors. The competition also serves as a positive way to bring DFNHS to the attention of younger doctors, with fresh ideas, and we have seen a modest benefit in recruitment as a result. The Executive Committee agreed that it would be fitting to rename the prize as The Peter Fisher Essay Prize, as a lasting memorial to our former President and I hope members approve.

It is strange to remember that, when the NHS Consultants Association formed, it was one of the first organisations championing the values of universal access to a comprehensive health service, regardless of the ability to pay. As the threats to those principles have multiplied in the intervening years, a whole host of national and local campaigning organisations have sprung up, focussing on specific areas of concern. The devolution of responsibility for the health services in the four nations of the UK has led to an even greater level of complexity, which is set to become much more challenging when the NHS in England is fragmented into 42 separate integrated care systems, each with their own constitution and budget.

While recognising the distinctive nature of DFNHS and the strengths of its combined membership, it would be very difficult to fight every demon assailing the NHS. Part of the role of the membership, through the Annual General Meetings, and the Executive Committee, in the interim, is to decide the priorities for DFNHS and whether some of those might be best served by working in alliance with other organisations.

I have been representing DFNHS on the Steering Group of our sister organisation, Keep Our NHS Public (KONP), which has become increasingly active in recent years. The failure of the Government to launch a comprehensive public inquiry into the handling of the pandemic, while the memory of the experience is still clear, provoked KONP into joining the People's Assembly in setting up the People's Covid Inquiry. The evidence sessions make essential viewing and the final report is keenly awaited. I have been involved in a subgroup concentrating on a possible campaign about the lessons learned from the Test and Trace programme. I would strongly

urge members to support their local KONP groups – your professional experience and inside knowledge of the NHS, combined with their campaigning flair, makes for a formidable force.

DFNHS is also affiliated to Health Campaigns Together (HCT) and I maintain our input into that forum, which is intended to bring together health campaigning organisations with organisations representing those working in the NHS, including some of the health unions.This can be an important point of contact with parliamentarians, particularly when important changes in legislation are being considered, as now. I have had some discussions with people drafting possible amendments to the Health and Care Bill, particularly trying to reduce concerns around transparency and governance. Good contacts have also been made with We Own It, particularly around the Government bail-outs to private health companies and the opportunities for commercial interests to expand offered in the Health and Care Bill.

Two years ago, James Skinner of Medact (also Docs Not Cops and patients Not Passports) spoke to our annual conference, about the impact of the hostile environment on groups that were already marginalised, and the way in which this undermines the principles of universal access to comprehensive healthcare. NHS Trusts are continuing to demand payment for care from migrants and other patients who do not have settled status, even when they are obviously destitute, and the sharing of their data with the Home Office with a potential impact on claims for asylum. I have been representing DFNHS at recent meetings of Patients Not Passports and will be alerting members to five days of action taking place around England, once arrangements have been finalised. Hopefully many members will wish to show their support at these events.

Executive Committee member, Arun Baksi, is taking a prominent role in Our NHS Our Concern, a think-tank which is exploring many important issues in which we have a common interest, including the parlous state of social care, the dysfunctional disciplinary process and the potential for NHS trust boards to be more representative of the wider trust staff.There has been scope for joint working, and this may develop further.

There are circumstances where the distinctive experience of DFNHS members can best be expressed in our own voice, particularly the impact of NHS 'reforms' on the doctor-patient relationship; the subversion of "Service not profit" by commercialisation; and the damaging effect of the way in which disciplinary procedures are often misused by Trusts, the GMC and other health bodies. Executive Committee members, Arun Baksi, Malila Noone and Helen Fernandes and others have been working on possible approaches to the culture of blame and its effect on patient safety, individual doctors and the working environment, as described in the April/May Newsletter and previous articles. They are taking this debate more widely.

DFNHS submitted written evidence to the consultation on the White Paper on Integration and Innovation, including its failure to address the workforce crisis, its undermining of continuity of care and disregard of the importance of teamwork in the provision of safe and efficient healthcare. Unfortunately, scant attention was paid to our evidence in the drafting of the subsequent Health and Care Bill!

In the last meeting that Peter Fisher attended before his death, he suggested that DFNHS should carry out a careful, detailed analysis of workforce planning in the NHS, including the important issue of job satisfaction and staff retention, and make this our main focus for campaigning. In my role as an elected local authority member, involved in scrutiny of the health service in West Yorkshire, I find it appalling that so much of the reduction in the care available to the public is driven by lack of suitably trained staff to provide a safe level of

service and the absence of any effective plan to remedy the situation. It seems to me that there is much that DFNHS members could bring to this debate, from our collective experience. The AGM is an opportunity for members to suggest priorities for the coming year: may I use chair's privilege to back Peter Fisher's proposal?

[*This was accepted by the meeting unanimously.*]

Treasurer's Report: Peter Trewby, Treasurer

Summary

Total Amount in feeder account on 28/9/21 = £8,153 + £3500 in our current account.

Our principal outgoings since our last AGM have been £2000 to KONP, £2000 to NHS Support Federation, £2000 to the "Centre for Health and the Public Interest" (CHPI), £1000 to We Own It, £700 for Junior Doctors' essay prize and currently

£700 pcm to our Communication and Publicity manager (see audited accounts to June).

Figures 1 and 2 show fluctuations in our deposit balance over the past 12 months and over the past 6 years.

Subscriptions

Since our last AGM meeting, we have lost 27 members (5 deaths, 17 persistent non-payment/no reply, 5 various other reasons). A further 21 members are being actively pursued for non-payment. This year, we have 11 new members including 7 trainees, 1 GP, 1 Clinical Development officer, 1 neurology rehab officer. 1 undeclared. We currently have 630 members including 27 trainees and 36 GPs.

£700 Essay Prize

The Journal of the Royal Society of Medicine again agreed to collaborate with us on this year's prize entitled: "What lessons should we learn from the Covid-19 epidemic".

We received 79 excellent essays, some quite outstanding. Kamran Abbasi, editor-in-chief of JRSM, Colin Hutchinson and Peter Trewby were markers. At the time of writing we are waiting a final verdict from JRSM. Suggestions please for next year's essay title. [*send to: healthjournos@gmail.com*]

Audited accounts for year ending 30 June 2020 were available at the meeting.

Cost pressures for the coming year

To increase our social media presence and to manage the bi-monthly newsletter the EC has agreed to increase Alan Taman's fee to £1500 per month for 3 months and then back to £1000 per month. The cost of professionally zooming the AGM is £687 [*this was largely offset by attendance fees*]. It is likely that a blended meeting will be required next year as well. Both these mean we will have less money to give away in the coming year.

In summary

No pressing financial problems apart from the usual plea for new members and for ideas for causes to support in line with our aims of supporting the NHS.

Thank you to all those who pay their subscriptions promptly or reply immediately when reminded, and to our auditor Robert McFadyen who again has brought light and clarity to my accounts.

Communication Manager's Report: Alan Taman

Background

The last 12 months have seen the NHS placed

2021

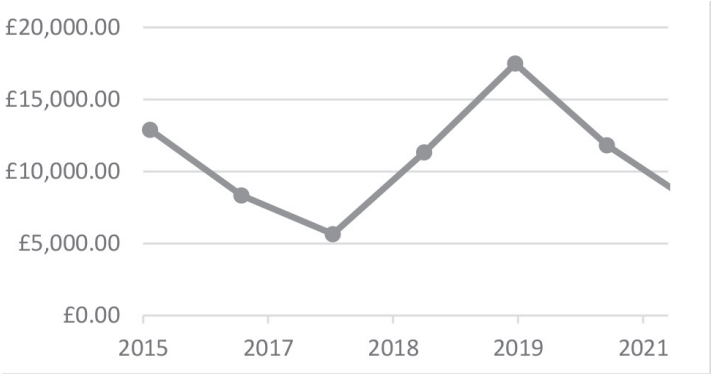


Figure 1 Deposit account in past 6 years.

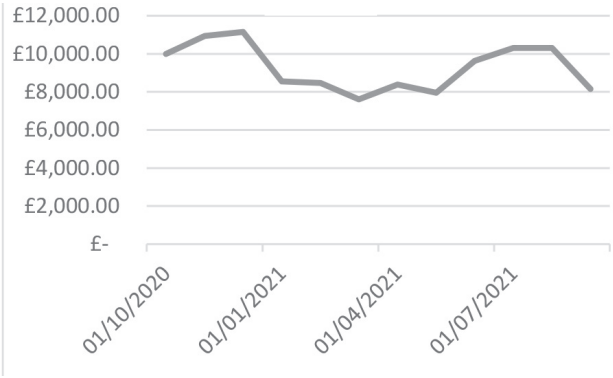


Figure 2 This year's balance, September 2020 - October 2021

under its greatest existential threat since it was formed. This is because of a combination of pressures arising from the pandemic, years of under-funding and under-staffing, and continued legislative change. These remain. Added to these are the immense social and economic upheavals derived from Brexit, and a government which continues to deny the scale of the emergency now facing the NHS and the public alike. The UK voted for a campaigning, isolationist, pro-privatisation government only a few months before the pandemic made much of this agenda even less fit for purpose than it would likely have proven to be anyway. This plunged the NHS into a highly uncertain year, and this is far from resolving as it heads into a winter which for many will be cruel and crisis-ridden – much of that caused or exacerbated by government action or inaction.

What these large-scale forces acting on the NHS have meant for DFNHS is that there are now multiple threats to address, and multiple positions to take, on a range of issues which although largely apparent before the pandemic have now become much more threatening. Staff shortages and the need to address the many shortfalls in treatment arising out of delays caused by Covid-19 present as one area of alarm. The continuing 'creep' of privatisation, increasingly manifesting as individuals choosing to put themselves into debt to 'go private' rather than face many more months of waiting, is another, with its attendant obvious co-existing problem that many in need of the same or more urgent treatment simply have no choice but to wait.

What this means for Communications

Last year a strategic oversight was recommended for communications, because of the complex and emerging changes listed above. It is now becoming apparent where effort needs to be made to address them, and with what degree of priority. These will be in the areas of staff shortages, NHS funding, and forthcoming legislative change. There will be other areas, arising out of obvious threats to the NHS and health in the past months. These will include the links between the NHS and social care. DFNHS needs to make choices for some priorities for further action, if only because attempting to address every threat now facing the NHS is beyond any one campaigning group. Focused, coordinated action is the key to effectiveness and DFNHS has a lot to offer. The first step in this is to decide which areas to prioritise. These will then determine which steps to take in Communications.

Media and other channels

With regard to press attention, comments on the appalling state of Test & Trace continued to be made and the increase in private provision was also commented on. Several national outlets approached us for comment on these over the year. It is now clear where future comments may best be focused: staff shortages, inadequate provision for treatment, and creeping privatisation, as well as on the likely changes arising from the NHS Bill. These areas will now be a priority for press comment, while making more comments more frequently.

The newsletter has now changed to bi-monthly and continues to be well received, with an increased contribution from external authors. The social media streams have continued to increase slowly in popularity but there is scope to develop these far more as part of a focused set of priorities.

Looking at DFNHS's own needs, the most urgent priority over the coming months must be to look at recruitment of new members. This could be done in the context of approaching other campaigning groups such as EveryDoctor UK, while maintaining DFNHS's own unique expertise and character, for explicit, targeted collaboration in defined areas where success is more likely and the group's defining characteristics add strength to that joined effort. We have much to offer, while the newer emergent groups have greater social media presence. Expanding the Essay competition to reach more doctors-in-training also provides a longer-term possibility to improve recruitment. Targeting of MPs in marginal constituencies may prove to be an effective tactic where members live in those constituencies. These steps for Communications will again be contingent on what priorities DFNHS sets to take.

[*These suggestions were agreed at the meeting, and have now begun to be acted upon,*]

2021

Finally, on a personal note, as my own circumstances change on completing my PhD I remain committed to doing everything I can to further the aims of DFNHS. I am convinced this group offers a great deal in the fight to protect the NHS in a way that is far from a convenient slogan. Careful, coordinated action is the key moving forwards, and this will be a critical part of my role.

Plans for the Future

Members discussed the following key points and EC will consider how best to action these at the next EC meeting.

The devolved nations

Involving the devolved nations and meeting their particular needs should be considered. Any suggestions as to how we might do this were invited. Chris Birt suggested an AGM in Scotland may be a good way to focus on this issue with our Scottish members. [*This has begun to be actioned.*]

Personal continuity of care from the point of view of doctors as well as patients

Work force planning and staff retention

Job satisfaction, training, working conditions and continuing professional development all relate to this topic

We should campaign for the workforce we need. Increased specialisation was supported by the Royal Colleges in the past and the lack of specialists is now used as a reason for closing down units and centralising services. Outreach clinics and out of hours services are also affected when specialists find they are unable to cover these services because they lack the confidence of generalists. We should be promoting a reversal to generalists with a special interest. RCP supports this idea but larger teaching hospitals are against it.

Colleges and specialist societies tend to 'cherry pick' areas to focus on thus removing a large number of patients from access to specialist care for less well defined conditions.

We also need to enquire into what supportive features encourage doctors to continue to work and contribute to the service. The essay competition could address this question.

The new bill may lead to a change in national terms and conditions. De-regulation and de-skilling will drive wages down and lead to dissatisfaction. De-skilling also affects quality as has been happening in pathology.

Increased bureaucracy and centralisation with larger staff groups vs smaller DGH type hospitals and communal working teams

Transport and reduced access to care is one of the issues following centralisation and loss of the local DGH. Access is a crucial issue for patients the public should show their concern and their concerns should be publicised.

Centralisation and privatisation may also impact on personal job satisfaction.

Eric Watts spoke of his experiences with the Success Regime in Essex. Arguments for centralisation

and change must be challenged. The requirement for specialist care for example does not hold true for most common chronic conditions when good basic care is the priority. On the other hand focussing on getting the 'cheapest' staff often backfires.

Efficiency and value of the NHS

Positive messages about the NHS must be publicised in the face of the government trying to shift the blame by not supporting GPs and setting up an Inquiry into NHS management implying inefficiency.

Each of the above areas threatens the NHS and patients. DFNHS should look into these areas given that one of our aims is to protect the NHS.

Responses invited by email to Alan (healthjournos@gmail.com) who will collate them.

Election of Executive Committee

Paul Hobday felt he could not continue to serve on the committee owing to other commitments and wished to stand down.

EC thanked hims for his efforts.

Alison Hallett, a trainee, was accepted on to EC.

Keep Our NHS Public Report

[This is an abridged version of the full report, which can be downloaded from https://bit.ly/3DUM82b.]

John Puntis summarised this for the meeting. KONP have continued to make a significant and positive impact.

John paid tribute to Peter Fisher for his inspiring activism and his role in setting up KONP. He was grateful for the continued financial support from DFNHS.

Main focus of KONP was the Peoples Covid inquiry with nine sessions of evidence from patients, NHS workers and international experts chaired by Michael Mansfield QC. All sessions are available on YouTube. Each session was also summarised and published in a *BMJ* blog which gave it wide coverage. Preliminary findings published comprise the manifestly obvious findings. Boris Johnson recently met with grieving families 396 days after he had first agreed to meet them and told them he was thinking of appointing a chair by Christmas. A potentially damaging inquiry is obviously being delayed and the fall out will be further minimised by adjusting the terms of reference. The People's Inquiry will be even more important as a contemporary record of the pandemic.

KONP has almost 60,000 twitter followers and 30,000 Facebook followers. Of 5000 per week website visits, 80% are first time visits suggesting that it is attracting people looking for information relating to support for the NHS. The Newsletter goes out to 8000 people.

Membership has increased to 1,600 and is increasing slowly with 70 affiliated groups. Working groups have been set up on integrated care systems, trade deals, general practice, Test and Trace etc producing detailed reports and campaigning materials.

In collaboration with Independent SAGE KONP is working on a charter on Health and Care in England which will be launched at the end of October in partnership with other organisations including DFNHS.

The KONP national team includes a campaigns manager 4 days/week, admin support 3 days/week, media/press officer 10 hrs/ week and a website manager 1 day/ week.

NHS Support Federation Report

The production of '*The Lowdon*' electronic newsletter in association with Health Campaigns Together continues to be a notable achievement.

2021

Speaker Reports

Compiled by Colin Hutchinson, Chair, DFNHS

Blinded by Corona

Professor John Ashton

Former Regional Director of Public Health for North-West England and President of the Faculty of Public Health.
John is working part-time with the West Sussex Public Health Team and the Grampian Public Health Team. His wife, Maggi Morris, accompanied him. Former Director of Public Health for Lancashire, she now works part time in Dudley and in Stoke.

John published his book, *Blinded by Corona*, co-written with Maggi Morris, in August 2020, as the first published account of the SARS-CoV-2 pandemic in the UK.

Last year he also published *Public Health Exposed*, co-written with Lowell Levin, which includes 50 stories of how public health medicine can change the world. *Blinded by Corona* was reviewed by Andera Franks in the January 2021 edition of the DFNHS Newsletter.(1)

Blinded by Corona covers the first 6 months of the pandemic, until "Independence Day" on 4th July 2020, when the lockdown measures imposed by the government in England, were lifted. Things were happening thick and fast through those months, so memories can become jumbled, leading to a confused recollection of the sequence of events. John kept a detailed diary during that time and this book can help refresh memories of the sequence of events during those tumultuous months.

The book includes an account of plagues throughout history, including those of the twenty-first century, including not only the 'Spanish' influenza of 1918/19, but also the Liverpool influenza of 1950, which began in the North-East of England, but had its most devastating effect in Merseyside: John caught the virus himself and recalls spending Christmas Day 1950 in his dressing gown. The background was set with an account of the downgrading of support for the discipline and practice of public health in England in the last 30 years, which left it less able to respond when it was most needed.

There was a sense of irony in this meeting being held in York, where the first two cases of Covid-19 were identified at the beginning of February 2020, in a student returning from China and his mother. When they were transferred for care in Newcastle, Chris Witty, the Chief Medical Officer for England, posted that it would probably all be over in a few days.

Meanwhile, events on board the American cruise ship "Diamond Princess" were giving a hint of the dangers posed by this virus in closed

communities, which seemed to be largely ignored. There was an interesting illustration of the above decks / below decks scenario, with Philipino sailors bunking in dormitories in the bowels of the ship, being called upon to care for hundreds of sick passengers and then going back to their dormitories, where infection was easily spread. At least 700 people became infected and nine people died. It could be seen as an illustration of the differential impact of the pandemic on different strata of society.

Politically-led science and the numbers game

In England, the Government often repeated that it was being "guided by the science". An important plank of this was the Scientific Advisory Group on Emergencies – SAGE. This unfortunately had many limitations, including the way it was so narrowly drawn, predominantly from a relatively small group of white male academics based at University College London, Imperial College and Oxford University. There was a lack of historical perspective and anthropological expertise, despite the important contribution identified during the response to ebola in Sierra Leone. It is incredible to read the advice from one of the modellers from Imperial College, that it wouldn't make any difference to allow the Cheltenham Festival and the Champions' League match between Atletico de Madrid and Liverpool to go ahead in March 2020. They noted that the match would only be going on for a couple of hours and everybody would be facing the same way, so they wouldn't infect other people. This showed a complete lack of lived experience of an international football match: a city becomes a party for 24 hours, with people drinking and mingling, let alone travelling to the match.

The chapter, "Politically-led science and the numbers game" describes how we were led down the garden path by remarkable statements such as those of Jenny Harries, Deputy Chief Medical Officer: stating that wearing masks would make the disease worse; about social distancing; that testing wasn't appropriate in the British context, but was for developing countries. The numbers game was played for all it was worth: not being told about deaths in care homes for several months, until it had been revealed that there had been a parallel epidemic taking place in care homes, after the political order to free up a third of hospital beds by discharging untested patients to care homes, without first checking whether they had the facilities to isolate such patients; the change of definition, to only count people who had died within 28 days of a positive PCR test; and not counting people who had died at home, without being tested.

Issues of trust are at the heart of this, an area in which John has become particularly interested in recent years, because it is very difficult to mobilise a community response to a big public health threat without a trusting relationship between the government and the governed; between the profession and the public. There was a need for openness and transparency and highly effective communications, not politically manipulated communications and slogans.

The forgotten

John has been interested in the situation in prisons throughout the pandemic. Anyone who as had experience of conditions within our Victorian prisons will be aware of the poor conditions, with inmates doubling up in cells designed of one man – potential powder kegs for spread of infection. We know that at least 20 prisoners and 30 prison officers have died of Covid, but the full figures have not been published. The risk of spread of infection was managed by keeping inmates locked in their cells for up to 23 hours a day.

2021

What have we learned?

The mistakes of the first 6 months continue to be repeated, like Groundhog Day, and we are currently seeing it in schools. There has been a failure to sort out testing in schools. Head Teachers have been put in an invidious position in the last two weeks, with mixed messages from the Government: they are told that, if a child tests positive, they should isolate, but any siblings should go to school as normal. When deciding how to respond to an outbreak in their school, their chief priority is the continuity of school attendance. Today, the rate of positive testing in schools is about one in twenty.

Communication breakdown

Clear communication from a trusted source is crucial in mobilising a community response to a serious threat to public health, but at a very early stage, in February 2020, John was asked to give an interview outside Arrowe Park Hospital, where the evacuees from Wuhan were in quarantine: the first of some 200 interviews, because the media struggled to get anyone to speak to them. Local Directors of Public Health had had been told by Public Health England that they were not allowed to speak to the media, but Public Health England would not speak either.

Boris Johnson was conducting a vendetta with the Today programme, so nobody from the Government was allowed to appear. When John appeared with Chris Witty on the Today programme, on 10th February, it was the first time that Chris Witty was allowed to speak, nearly 2 weeks since the first cases were identified in England.

Planning for the worst while aiming for the best

In 1999 there was a hypothetical risk that the world's computers would cease to function at the millennium. A huge amount of time and money was devoted to preventing this, but when the millennium passed and nothing happened, all the tabloids howled, "What a waste of money!" This is a dilemma you always have to face in public health: it is the problem of making the invisible visible, so you can deal with it. Immunisation against childhood infections, such as diphtheria, is still really important. Until 20 years ago, you could have used an eye-witness account from the generation before such immunisation became possible, to tell how their school friends died from diphtheria. We now have to find other ways of making this tangible.

John's advice was that we needed to take this seriously. It required open and transparent dealing with the public, because you might have to take them on a very difficult journey, as we have since found out. But once that trust is lost, things become very difficult. How many people did you see wearing masks on the train that brought you to this meeting?

A different country: a very different approach

Two days after the Arrowe Park interview, John was phoned form the office of Crown Prince Salman, in Bahrain, asking him to go and meet key people working on their pandemic response. They had set up a "war room" with wall screens providing real-time information, unlike the limited information released by Public Health England, unfiltered, from the Centre for Disease Control at Johns Hopkins University and other sources and 30 people under the charge of Colonel Manif Al Quatani, who had trained at Trinity College Dublin. John was asked to examine their plan and give critical feedback, so he visited the airport, the seaport and the causeway connecting to Saudi Arabia. He visited the labour camps housing thousands of workers from Indonesia and elsewhere, living in rather squalid

municipal-type housing. He visited the prisons. He visited the hospital, to make sure they had set up the reception, triage and quarantine facilities, and the laboratories.

There were only two small PCR machines, but a quick calculation of the demand for testing at the borders suggested another three or four machines were needed and when John returned, two weeks later, they had got all the necessary kit from Saudi Arabia, with a machine at the airport, capable of testing thousands of people a day.

Within 10 days they had built a Butlin's-style quarantine camp on an island off Bahrain, including playgrounds for children and sports facilities for the men.

They were due to host the Formula One Grand Prix in March, but John advised they postpone it – and they did. He saw the prisons minister and explained the current prison posed a high risk of spread of infection. There was a new prison, but it was yet to be commissioned, so John advised that some prisoners be released, and within 3 days, 900 prisoners had been released.

It was a remarkable experience, professionally, to have somebody listen to you, and act!

The contrast was even more stark when he flew back to Manchester on the day of the Atletico Madrid match. He couldn't believe what was happening.

We've been here before

There is a Penguin book about the 'Spanish' influenza pandemic of 2018/19 titled *The Great Pandemic*, which John recommends highly. That pandemic probably started in a disadvantaged county called Haskell, in Texas. A country GP, Loring Milner, had an interest in science and had set up his own laboratory, to try and find out what was going on when several local men developed a severe form of influenza. He notified the American Public Health Service, but was ignored.

The local outbreak faded away, but a couple of months later, there was another outbreak on a nearby military base, but President Woodrow Wilson was distracted by his ambition to win the war in Europe and nothing could be allowed to stand in the way of mobilising two million Americans and transporting them to France. They brought with them the influenza, which wrought havoc, particularly amongst the German forces, and may have played a part in the failure of their final offensive. It went away in the summer, only to return with a vengeance in winter, and was spread round the globe by demobilising troops, leading to a death toll of 50-100 million people. Censorship prevented it being reported among the allies, so when it was identified in neutral Spain, it was christened Spanish Flu.

This ignorance, when dealing with a novel airborne virus, was largely repeated with Covid-19. Government advisers were misled into thinking it would behave like influenza and a resulting over-emphasis on potential spread through contamination of surfaces, when we should have been considering spread by aerosols and taking more appropriate protective measures.

An aphorism from "Public Health Explored" may go some of the way in understanding how we went so badly wrong:

> **"The person who frames the question, determines the range of solutions"**

Reference

[1] Available at: https://bit.ly/3FBxrRF

2021

'Fixing' Care for Good

Jan Shortt

Jan Shortt is General Secretary of the National Pensioners Convention, which campaigns for the welfare and interests of all pensioners, as a way of securing dignity, respect and financial security in retirement. It has about 1.5 million members, through 1000 affiliated bodies and has led many successful campaigns since it was formed in 1979, including restoration of the link between the state pension and earnings; the winter fuel allowance; the free concessionary bus pass and extension of the period before an in-patient has their pension stopped, from 6 weeks to 52 weeks.

We all need care at some point in our lives and that need increases with age. The general public believe that, if the time comes that they need care, it will be provided for free.

Nobody in government attempts to make people understand that social care has never been free. Many people think there is a cap of £72,000 on care costs – there was going to be – but the Coalition Government scrapped those plans in 2011. When the time comes that they or a family member needs social care, this comes to them as a huge shock.

Where is the fairness?

The funding of social care is widely acknowledged as grossly unfair. Before we retired, all of us paid income tax, National Insurance, VAT and council tax, and continue to pay various forms of taxation, but we are treated very differently when it comes to funding our care. Consider four scenarios:

- Molly lives alone in her own property. She has dementia and needs to go into a care home. She has an income and savings of more than £50,000 and owns a property worth £300,000. She will have to pay all her care costs, until her income and assets reduce to under £23,250, at which time the local authority will begin to pay for some of her care costs.
- Malcolm and Mary live in their own property. Mary has dementia and Malcolm is no longer able to look after her at home. She has to move into a care home. Mary has income and savings of £20,000 and jointly owns property with Malcolm, worth £450,000. Because Mary's personal income and savings are less than £23,250, she has to pay only part of her care fees and her local authority pays the rest. Her property is disregarded from the financial assessment, because Malcolm still lives in their home.
- Margaret lives in rented accommodation. She has suffered a stroke and needs to go into a nursing home. She has income and savings of less than £10,000 and does not own any property. All her care costs are paid for by the local authority. Because the local authority buys its places in nursing and care homes at a cheaper rate than those who fund themselves, Margaret's care is effectively being funded by Molly.
- Michael lives alone in his own property. He has cancer and is treated in hospital. It does not matter how much income, savings or property Michael has, because the care he

receives is provided free by the NHS, and is funded through general taxation.

Care is means-tested through a complex formula that takes in things like your regular income, extra income from investments, savings, other sources. It can also include the value of your home if you own it and its contents. That is dependent on individual circumstances and who else has the right to live there:

- Currently if you have assets over £23,250 you will pay the full costs of your care (self-funding).
- If you have assets of between £14,250 and £23,250 you will make a contribution to your care based on capital and the local authority makes up the balance.
- Less than £14,250 in assets, your care is funded by the Local Authority.

However, there are anomalies to this system which mean that in lots of cases, and families are often asked to 'top up' the gap in funding. Self-funders pay around 40% more for their care.

There are some differences across the four nations of the UK, with the bandings being slightly more generous in Scotland and Wales – but only slightly.

Continuing Health Care budget funds mainly complex health conditions on a long-term basis, but this funding can be reduced or withdrawn due to cuts in budget. They often require complicated assessments as to what needs can be defined as 'health' and which are 'social' and decisions can be opaque.

The spend on care is currently £23 billion – £15.7 billion on residential care and £7.3 billion on home care. The government would have you believe that the care system is at breaking point because of spending on social care for older people. Not true. Over 50% of the care budget is spent on working age disabled adults.

Building back better?

Let's not be complacent about what the Prime Minister offers as his 'fix' for care. It is in fact the smallest sticking plaster, which is expected to cover the large gaping hole in the care system. Far from making a positive difference to the lives of those who work in the care sector, those who receive care and those who may need it in the future, and the huge army of unpaid carers, there is very little change. Putting money into an already crumbling system will not achieve anything like the radical changes needed to ensure that everyone has the quality care they deserve at the time they most need it.

Let's explore what this 'fix' means for both the NHS and the care systems. What is on offer in 2023? (1)

The quality of care will still be relative to a person's ability to pay for it.

5.4 million unpaid carers (including those over 65) provide care valued at over £100 billion a year – nearly five times the amount spent on publicly funded care. In financial terms the carers allowance is £67.60 per week. There is a vague promise to 'take steps to help unpaid carers get support, advice and respite.'

Most of the 1.5 million care workers are employed by private companies and on average earn £8.50 a hour. 112,000 vacancies exist in the care sector and nearly a third change jobs each year which affects the continuity of care for those in need. The £500 million earmarked as investment in the care workforce, spread over 3 years is about £2 extra per week per worker. But, this won't actually appear in their pay packets. It is supposed to 'support professional development and long-term well-being'! What difference do they think

this will make to resolving the workforce crisis?

The care cap is raised from £72,000 to £86,000 over a lifetime. Only 1 in 7 paying for their care will benefit from this, in part, because this cap is only for costs relevant to personal care – accommodation costs are not included – and the costs are based on what the local authority would have paid, not the costs actually paid by a self-funder. Accommodation costs, glibly referred to as 'hotel costs', include food, laundry, whether you want a TV in your room, or a walk-in shower rather than a bath. These are the kind of things people will still have to pay for if they are paying part of the cost of their care.

Those with assets between £20,000 and £100,000 will be means-tested for help. Those with less than £20,000 will not have to pay care costs from their assets, but may have to contribute from their income.

Selling homes to pay for care will still be a feature and it isn't just your home – it is everything in it. And the absolute distinction between people suffering from cancer and those with dementia will remain.

The money on offer is less than we think. Over the next 3 years, only £5.4 billion of the £36 billion raised through the regressive health and Social Care Levy will go on social care. About half of that will go into care services, the rest will go towards replacing the money that people with assets will no longer contribute as a result of the cap. Less than a billion a year then. The government says £2.2 billion will be made available to Scotland, Wales and Northern Ireland, but it is unclear how this will be distributed.

The fundamental problems of equality of access and quality of care will remain as soaring costs and squeezed council budgets may only run to brief and infrequent home visits or a cheaper, inadequately staffed care home. We will still see those in need left to find support from family and friends; having to navigate the complex market place of care; or, as 1.8 million people already do, go without – risking degeneration of health until it reaches a critical point.

Won't the Health and Care Bill help?

We have the promise of yet another social care white paper at a future date, despite 12 consultations and 5 reviews in the last 20 years and we must not forget the ill-conceived Health and Care Bill or Peter Lilley's Elderly Social Care Insurance Bill which is something else! The real concern is that a promise to 'reform' social care comes only after the government has 'integrated' the still means-tested, privatised care system with the NHS.

The NPC does not accept integration as a saviour of the problems – rather more a problem in itself. As proved with the plans for the increased income from raising National Insurance, the NHS will always have first call on resources – financial or otherwise. Under that method, social care will always remain the 'poor cousin' being thrown crumbs from the table that will never give a quality of service to those of any age in need.

We need a National Care Service

The National Pensioners' Convention supports the idea of a National Care Service which would be a universal service delivering the same quality of care, either at home or in a residential setting, free at the point of need and funded through general taxation. A National Care Service under our policy would be a stand-alone function, managed and funded independently of the NHS, with public money and public accountability. This policy was launched in June 2021. (2)

Our proposals for funding are based on redistribution of wealth through a progressive tax system and could involve a combination of some or all of the following:

- Equalise the tax rate for Corporation Tax and Income Tax
- Reduce or abolish the Corporation Tax Allowance
- Cut or abolish the subsidy to pension contributions for the wealthy which costs £10 billion a year
- Regularise National Insurance so that those earning least do not pay more than those with higher incomes.

Another area to look at is the huge amount of money being leaked out of private providers (especially equity funded ones). For example, HC1 with a business model that never seems to make a taxable profit – located in tax havens – reports a loss every year. Since 2011, HCI has never paid corporation tax and paid out at least £48 million in dividends in 2017/18 alone.

Social care is completely broken and only radical change will give us what we truly deserve. We are still among the richest countries in the world despite the pandemic. It is the way our government choose to spend our money that is the problem – political priorities, not citizenship needs.

It is perfectly possible to have a fully publicly funded NHS and a fully publicly funded National Care Service working alongside and in collaboration with each other, for the good of all. The political will to ask us what we need and provide it, like any good government should, is what is missing.

References

[1] https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care
[2] https://www.npcuk.org/post/goodbye-cinderella

Further information is available from:

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2021

What we can learn from the pandemic to help reduce future health inequalities?

Professor John Wright

Director of Bradford Institute for Health Research and Wolfson Centre for Applied Health Research and Visiting professor of Public Health, University of Bradford, York and Leeds

John described his personal journey, which involved going to work in a mission hospital in Swaziland, with his wife, Helen, for 3 years, in the early 1990s, after completing his general medical training.

The hospital was on the border with Mozambique, during the time of a bitter civil war between RENAMO and FRELIMO and the mission served two large refugee camps run by the United Nations High Commission for Refugees, housing 250,000 people. It was a turbulent time, as the apartheid regime in South Africa was in its final throes. They worked in a three-doctor hospital, performing obstetrics, paediatrics, general surgery and trauma. The experience stimulated his interest in epidemiology and prevention of disease. HIV was sweeping through the population. Many evenings were spent in theatre dealing with injuries from cars running into cattle in the dark, when it would have been better to be building fences to keep the cattle from straying.

We tend to work in a hospital or GP practice for 30-40 years of our life and the sense of place is very important to us. Even in this setting of great poverty, TB, 40% of the population infected with HIV, there was joy, laughter and a sense of connection. The importance of trust was also clear, when trying to deal with fairness and tackle inequality.

In 2015, he was working closely with the British Army in Sierra Leone, during the Ebola pandemic there and witnessed the great work the military were doing. They were building and running an isolation hospital and immediately rumours started, that there were white men in the hospital, injecting people with Ebola, with loss of trust in the facility. Experience from the Covid pandemic reinforces the importance of building trust in the community. It is interesting also to reflect on the geopolitics of disease: malaria was killing far more people than Ebola was ever going to, yet far less resources were applied to tackling malaria.

On their return from Swaziland, John did some public health training. Liam Donaldson was Regional Director and he was setting up Clinical Epidemiologist posts around the coutry, one of which was in Bradford, which allowed him to combine clinical work with an MD in epidemiology and he developed a fascination with the city. It is the fifth largest city in the UK, but is very poor, with 14 of the poorest wards in England and a very diverse population. Fifty per cent of the population is under 18 and 50% are of South Asian heritage, mainly originating from the Mirpur region of Pakistan. It has been a crucible of public health innovation.

Understanding strengths and vulnerabilities

In March 2020, as the pandemic took hold, he shared a sense of horror at the lack of effective action to bring the situation under control. It was very clear that a city like Bradford, with multigenerational families, living in overcrowded housing and poor social conditions, was going to be hit badly. So a week before lockdown was ordered, they began telling people to stay at home and the sense of trust that had been built up previously, did mean that people actually listened to the message. In February and March, they worked with the hospital to apply some of the lessons from isolation hospitals, such as those in Sierra Leone, to local hospitals, which had never been designed as isolation centres. But Bradford had an advantage due to the great epidemiological and clinical expertise that has been built up in the city, largely due to the Born in Bradford study, which will be described later.

They set up a Covid advisory group – a Bradford SAGE – as part of an approach to involve the community alongside clinical expertise, and as the lockdown continued, we hoped the sense of disconnection between the community and the NHS and local government might be bridged via the Born in Bradford project. They had built up a group of 50,000 people who are tapped into the science of population health and able to take part in polls that they hoped could help take the pulse of the population as the months went by.

These polls captured a sense of some of the economic, financial and food insecurity, particularly among the self-employed, or those on low wages, who found themselves on furlough. If you are already on the borderline, a 20% reduction in income can mark the difference between survival and non-survival.

Just before the pandemic started, they had done a survey of 16,000 primary school children, which showed 30% had no local green space, so they couldn't take advantage of all those sun-filled days in April, May and June. 26% were worried about money all the time, 50% were worried about being bullied and 30% kept their worries to themselves. (1) So the seeds of mental ill-health were being sown at that time and correlated to mental ill-health in their parents. If you were comfortably off, the lockdown could actually be quite a good time, allowing more time with close family, exercising, in your garden, but the poorer you were, the harder it affected you, as shown through anxiety/depression scoring.

Work was also done through qualitative studies, using focus groups. The earliest investigations of vaccine hesitancy, and how it might be addressed, came from Bradford. (2) That loss of trust from people who thought that vaccination would involve them being infected with Covid brought back memories of Ebola. The poorer you were, the more you were likely to have these fears and ethnicity made a big difference. As well as lack of trust in national and local government, for the first time they were also picking up a loss of trust in the NHS. But they were also able to work through their established networks to increase vaccine uptake through work with community leaders and having vaccine hubs set up in mosques and other diverse settings.

It is very difficult to know how much difference this all made. Bradford was within the top 10% worst affected local authorities, but the standardised mortality rate was low, so it might have helped.

Remembering what happened

When John was working in Sierra Leone, the BBC gave him a tape recorder and asked him to take it round with him as an audio-diary. During

the Covid pandemic they asked John to do the same, so he blew the dust off the recorder and captured the voices of his wonderful colleagues and his patients and they give a sense of the almost Shakespearean tragedy playing out in those early months. There was such a tight control of the media imposed by NHS England, but these recordings did capture the fear of people, crying as they came onto the Covid wards; patients who were desperate and scared; but also the resilience and strength of patients and staff. These recordings are still available on BBC Sounds as The Coronavirus Doctor's Diary. (3)

Money as medicine

It is not just Bradford that was hit hard. The pandemic wreaked greatest havoc in poorer areas across the whole country. So how can these structural problems be addressed? If you come to Bradford, try to visit Haworth, the source of so much of the inspiration of the Bronte family. You can also find there, the evidence of how many children died from infectious diseases. Since then, life expectancy has steadily risen, until 2011, when the increase slowed and, for the first time in peacetime, last year stalled and started to fall in certain groups, particularly in poorer people. (4) Money is central to this. Money is, perhaps, the most important medicine, and yet we do not seem to be giving that medicine where it might have greatest effect.

If we consider relative poverty, where income is less than 60% of the national average wage, there was a sharp increase in the early 1980s, particularly affecting children and adults of working age. From the late nineties, through the first decade of the 21st century, the rate of relative poverty fell amongst children, only to rise again over the last decade. (5) We might like to consider the wisdom of closing all those Sure Start Centres, now that evidence of the long-term health benefits is becoming apparent. (6) The fiscal element plays a central role in inequality. Recently, households in the poorest deciles have lost the greatest income, and the richest have done best. (7) The recently announced rise in National Insurance is yet another regressive tax, which is going to lead to further health inequality.

Understanding complex systems

Consider a marker condition – childhood obesity – which has risen and risen in prevalence. The rise is not occurring in all parts of the population. It particularly affects those living in deprivation, leading to greater risk of diabetes and osteoarthritis. Mental health is another marker condition. Despite all the resources that have been channelled through the NHS, it has worsened over the last 30 years. No medical treatment seems to have made a dent. We need to do something fundamentally different.

Born in Bradford has been looking at childhood obesity – at the early origins of the adult disease. Half of the children in Bradford are of South Asian origin, predominantly from the Mirpuri region. Evidence, including DXA scanning, has shown that these babies might be smaller, on average, but they have a higher proportion of fat tissue, in a central distribution, associated with a higher risk of cardiometabolic disease. This leads to an underestimation of obesity and overweight of 20%, if you were simply to rely on BMI. The risk of diabetes in South Asians is 4-5 times higher than in a White British person, and it tends to occur at an earlier age. (8)

The impact of environmental factors is becoming increasingly apparent. These 40-50,000 Bradfordians have changed science in a remarkable way. Their participation has demonstrated the harm of air pollution during intrauterine development, low

birthweight, smaller head circumference, through to childhood asthma. 25% of these children have a wheeze and one in seven have been diagnosed with asthma by a doctor. 38% of cases of childhood asthma in the city can be attributed to air pollution. The effects show up at a cellular level – the closer you live to air-polluted roads, the shorter the telomeres in your cells. They have shown the beneficial effect of access to green spaces on mental health. Pesticides that were banned 30 years ago are still being detected in our children's blood.

These children are now becoming teenagers. The Wellcome Trust has just agreed to fund a new phase of the study, called "Age of Wonder", to try and capture these tumultuous years of physiological, social and physical change during the transition from child to adult., with a particular focus on mental health. We all know the impact the last 18 months has had, particularly on the mental health of children and adolescents, with the disruption of education and social connectivity, uncertainty, Brexit, austerity, and again looking at the differential impact associated with ethnicity and economic status.

After 14 years of Born in Bradford, John is most struck by the influence of social patterns on all aspects of our children's development. They are much more complex and harder to tie down, than a simple agent like a SARS virus, and the solutions are much more complex. If we consider a group of children living close to the hospital in Bradford, they are more likely to be growing up in damp, poor quality homes, with kitchen facilities that don't lend themselves to preparing good food; an environment full of fast-food outlets with few healthy food choices; a lack of green spaces near them; poor quality air to breathe, due to the roads, and a greater danger of being injured by traffic; more exposure to crime; likelihood of worse schools; and barriers to attainment from diverse languages – a complex combination of interacting factors.

And yet, as doctors, we all tend to focus on individual behaviour. When that great epidemiological duo of Richard Doll and Bradford Hill clearly demonstrated that smoking was bad for you, doctors very quickly gave it up. The people wearing Fitbits and eating quinoa salads are largely the middle classes. The wealthy elements of society are adapting to healthy choices, but for the poorer parts of society it is not so much about individual choice, or bad judgment, it is more related to the complex system just described. Our approach needs to be not so much one of behaviour change, but more about physical and legislative change. An example is the sugar tax in Mexico, which has produced a marked shift towards consumption of bottled water, allowing drinks companies to maintain their market share.

John reflected that over the last 18 months, we have been like children playing football on a Saturday afternoon – all chasing after the Covid ball, while the open net of non-communicable disease lies neglected in the background. Non-communicable diseases kill 5-10 times more people each day than Covid, and will continue to do so. They are not so easy to deal with, because diseases like obesity are not linear. Like weather and climate change, they have feedback loops, which can amplify or dampen the effects and may have tripping points beyond which changes become less reversible.

Making change happen

We need to rid ourselves of the notion that we will find magic bullets for each of these problems and look to changing the whole system and in recent years, Born in Bradford has been trying to understand better this whole system. John has been working more closely with local government, with less of an emphasis on hospitals and more on changing urban design, our built environment, housing, transport, schools, art and culture and trying to apply science to these areas, but for this to

happen, we come back to the importance of trust in place, community engagement and grassroots involvement. We have to bring the whole community with us and build on their assets, rather than ignore them. The work that has been done on the harmful effect of air pollution has led to the imminent implementation of an ambitious Clean Air Zone and the clean up of the most polluting buses. Work with the community is concentrating on mitigating the impact on those who might be adversely affected economically.

John makes the point that data is fundamental to epidemiology. There is a huge mass of data held in various records within the health and the educational systems. If this can be brought together, it can be a very powerful tool to identify who might benefit from help and how it might be targeted. In Born in Bradford, all mothers and fathers are asked for their consent to routine data links between health and education. This has enabled the study to show that the statutory Early Years Foundation Stage assessments carried out by teachers were highly predictive of autism and that attainment levels were improved if this was recognised early, so that information was used to redesign local autism services. They were also able to show that a child born prematurely during the summer months suffered a particular disadvantage if this meant that they entered school a year earlier than if they had been delivered at term. Local authorities were persuaded to delay admission to school till the following year as a result of this evidence.

This account can only give a glimpse of the potential for Born in Bradford to produce high quality evidence for the elements of the complex environment in which we live and their impact on our health. How and whether we choose to use that knowledge to reduce the misery and disability that unequally affects the various members of our communities, is a matter for us all to decide. John Wright's work has given us ideas of how we can approach these complex problems and how we might assess our progress. Further information is available on the Born in Bradford website. (9, 10)

References

[1] https://borninbradford.nhs.uk/research/publications/vulnerabilities-in-child-wellbeing-among-primary-school-children-a-cross-sectional-study-in-bradford-uk/

[2] https://borninbradford.nhs.uk/research/publications/covid-19-vaccine-hesitancy-in-an-ethnically-diverse-community-descriptive-findings-from-the-born-in-bradford-study/

[3] https://www.bbc.co.uk/programmes/articles/28KX654ld2895YwGDNXzLjk/the-coronavirus-doctors-diary

[4] https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-england

[5] https://researchbriefings.files.parliament.uk/documents/SN07096/SN07096.pdf

[6] https://ifs.org.uk/uploads/WP202125-The-health-effects-of-universal-early-childhood-interventions-evidence-from-Sure-Start.pdf

[7] https://ifs.org.uk/uploads/R194-Living-standards-poverty-and-inequality-in-the-UK-2021.pdf

[8] https://borninbradford.nhs.uk/research/publications/differences-in-total-and-regional-body-fat-and-their-association-with-bmi-in-uk-born-white-and-south-asian-children-findings-from-the-born-in-bradford-birth-cohort-version-1-peer-review-1-approved/

[9] https://borninbradford.nhs.uk/wp-content/uploads/BIB_Supplement_Magazine_2019_Web.pdf

[10] https://borninbradford.nhs.uk/research/publications/

The Paul Noone Memorial Lecture Covid: A spotlight on our challenges

Professor David Oliver

David Oliver is a consultant in geriatrics and general internal medicine at the Royal Berkshire Hospital. He is a visiting professor at City University, a trustee of The Nuffield Trust and a King's Fund Fellow. He was previously a government National Clinical Director, President of the British Geriatrics Society and Vice-president of the Royal College of Physicians. He is also a freelance medical journalist in professional and mainstream publications, with a weekly column in the *British Medical Journal*.

I think it's important to consider the health and care landscape before the pandemic struck, if we are to understand how we arrived at this point and how we might face the challenges ahead. I will also use my own experience to illustrate some of the strengths and weaknesses of the response.

The first Covid death in the UK occurred in my trust and I looked after the second. I also recall one day in which I had five people with Covid die within 90 minutes. This was in the first wave, when no relatives were allowed to visit, so it was a particularly traumatic time, even for relatively experienced doctors like me.

Already weakened

It is easy to blame everything upon the pandemic, but the NHS was not in robust health before we ever heard of SARS-CoV-2.

Elective treatment

A combination of increased funding and New Labour's process targets had brought waiting times for elective treatment to a historically low level. Well before Covid, shortly after the spending review of the Coalition government, performance on elective waiting times started to tail off and, before Covid, waiting times were at a record high. (1)

Demand for Primary Care

The number of consultations in general practice has risen year upon year, despite no increase in the number of full-time equivalent GPs and, despite the *Daily Mail*'s thirst for GP bashing, 56% of GP consultations are currently happening face-to-face. (2)

Demand for emergency care

This year, attendances at A&E departments and emergency admissions are at an all-time high. Over the last 15 years there has been a steady increase. (1) The number of emergency admissions has gone up disproportionately, despite far more senior decision makers, because there has been an increase in the complexity of cases. (3) The core business of these departments is older people with multiple conditions. At the start of my career as

a Consultant Physician, we'd do a post-take ward round and see people from the night before: now we have Consultants working till 9 or 10 in the evening, 7 days of the week, pouncing on people and trying not to admit them, and still we have this increase in admissions.

Since 2014 we have not met the target of 95% of A&E patients treated within 4 hours, and every year our performance has got worse. (4) To give you some context, in my own trust only 6 years ago, we were seeing 250-260 attenders in 24 hours: we now average 340. Since September we have had 470-500 each day and that has been occurring all across the Thames Valley.

Hospital bed availability

In the UK, we have a third fewer hospital beds than in 2000 and if you consider England alone, almost the lowest per capita bed base in the whole of the developed world. The UK is just above Sweden and Denmark, but of course, they have invested heavily in community services. (5,6) No wonder we were panicking during the pandemic when we were seeing what was happening in Italy, Spain and France, when hospital services were falling over despite them having more beds per capita and more intensive care beds than we do. You could say we did remarkably well, all things considered. There has been a sustained reduction of beds due to advice from big consultancies making over-optimistic assumptions, with new hospital units being built housing fewer beds than before and in fact the Nuffield Trust was prophesying 5 years ago that, if we carry on with the current level of activity we would need the equivalent of another 20 District General Hospitals.

Bed occupancy before the pandemic was running at well over 95%. (7) I won't get into the boring technicality of how this is counted, but I will explain how that feels. I work in a big DGH with 800 beds.

When you come into work in the morning, it's quite normal for us to start the day short of 60-70 beds. As we're seeing people during the morning round we are in a desperate race to free up beds and, as we don't separate elective from emergency beds in this country, that then spills over to impact elective activity. Mathematical modelling shows that 85% is the optimal bed occupancy to allow smooth patient flow, but if you want headroom for a big surge on a busy day, you certainly can't run at 95%. There are also concerns that high bed occupancy can contribute to nosocomial infection.

Critical care bed capacity

We have only about half the number of critical care beds compared to Italy, France or Spain and a quarter of what America does and yet we saw services in those countries falling over. It's possible that, because we were already quite restrictive in who we admit, we were able to cope better than some countries. (8)

Health spending

We are not noticeably under-funded compared with a lot of developed nations. (9) We spend just above the median per capita for the OECD and significantly above this as a proportion of GDP, so

we're not notably under-funded compared with a lot of developed nations, but the trend over time, using data from the three big health thinktanks, shows the impact of the Coalition Government's spending review. (10) The average annual increase in NHS spending across its history has been about 4% per annum. (11) During the Blair / Brown years we had around 6% annual increase, but since then we have come nowhere close and even the Labour pledges at the last election would not have brought us anywhere close.

You can see the impact of this underinvestment. Trusts began to run deficits by 2015 and the Government couldn't have trusts going belly up – most people only have one local provider – but this shows that, even with the top-ups, trusts were running deficits. And bear in mind, acute trusts get a disproportionate share of NHS expenditure. (12)

Social care

The number crunchers have shown that the so-called plan is something like £36 Bn to the NHS and Social Care over the next 3 years, but we don't know what is going to happen after that. (13))

And while £31 Bn is supposedly going to the NHS, the Health Foundation showed that, just to maintain current levels of social care service provision, would require £10 Bn gap by 2024 ... and they're getting £5.4 Bn. (14)

Social care is already heavily rationed and restricted with eligibility criteria. Many people with quite substantial needs are wholly reliant upon informal care from friends and family. The Health Foundation came up with scenarios of what would be required to meet future demand, improve access to care and pay for more care. Local authorities will still have to find the income from Council Tax and the Social Care Precept, which is a regressive tax because wealthier local authorities are able to raise more income due to higher property values, so it is not a solution to the problem. (15)

The Institute of Fiscal Studies has demonstrated just how regressive local authority funding really is. A third of local authority income comes from central government grants, and local authorities in more deprived areas have seen proportionately greater cuts. You can have high levels of need within more affluent areas – what isn't reported in the press is that half of adult social care spending is not on the elderly, but on younger adults with long-term disabilities. That wasn't acknowledged in any of the recent Government announcements.

Workforce capacity

If we look at the number of doctors and nurses per head of population, we would be short-staffed, even if all vacancies were filled. (16)

General Practice has been hammered particularly in terms of workforce numbers. LSE did a comparison of 11 high income nations in 2019 and showed our GPs are seeing double the number of patients than in any of those other nations. (17) Upstream disease prevention is important in reducing the demand for care, but workforce is the defining issue in terms of delivering care.

The three big think tanks produced a report, *Closing the Gap*. (18) I've picked out a few headline figures: 1 in 8 nursing vacancies is unfilled; 1 in 11 medical and allied health professional vacancies is unfilled, and of course some like paramedics are having a bigger crisis than most; there have been very big reductions in District Nursing and Health Visiting. In social care, vacancies are 1 in 4. The Government's points-based immigration rules explicitly exclude social care workers, the rationale being that these jobs should be filled by British workers and the sector needs to pay more, but of course they get their resource form local government, which has suffered swingeing cuts. The

market is rigged and you're going to have providers going under.

There are geographical inequalities: coastal communities and post-industrial towns on the outskirts of conurbations particularly struggle to attract staff. The report included a whole slew of very reasonable recommendations, about training, about terms and conditions, making staff feel more valued, focusing more on teams and flexible skills, and yet Davina Evans, the new Chief Executive of HEE, who is a consultant psychiatrist by background, suggested only yesterday that we need to be learning from low-income countries, which seems stupid. Our health and care staff are not living in a low-income country – we need to make it more attractive for people to work in this sector and stay within it, in the UK.

Impact of inequalities

You won't need reminding of the importance of health inequalities, but the report from Michael Marmot, released just before the pandemic struck, confirmed that the improvement in life-expectancy had stalled, particularly in more deprived communities and, even in more deprived areas of the south-east, such as Tower Hamlets, life expectancy was still better than in areas of Newcastle or Sunderland. (19)

Public perceptions

There is a very good report from a non-political organisation called Engage Britain, who spoke to 4,000 people, (20) Their report is consistent with the Patient Survey and the CQC that, in the main, the NHS is the institution that makes people feel most proud to be British. People value the NHS, and the public realise there are significant workforce challenges and shortages. However, people are really struggling with access, waiting times and navigating the fragmented system and feel abandoned, without continuity of care. They understand that often the reason is resource and workforce gaps, but people are increasingly unhappy with the offer.

As doctors, we too often become defensive and say, "Look how hard we're working and what else do you expect us to do", rather than, "We agree with you: the situation is getting worse. We hate working in a system that can't treat people promptly." We should be asking our patients to join with us in putting pressure on the government of the day to address the underlying issues.

But we had a plan, didn't we?

It was like pulling teeth – it took legal action – to get the government to release the Report on Exercise Alice from 2016. (21) It beggars belief: I worked in the civil service for several years; I've worked on the other side of the fence, the Royal College, lobbying and so forth. They said "officials" never released the report for ministers to consider. This is clearly nonsense. This exercise was not preparing for Covid, of course – it was for a MERS-like Coronavirus infection – but it was about the UK's preparedness to cope and revealed the lack of PPE, the lack of capacity in intensive care, the lack of bed capacity, the lack of workforce, the lack of ability to scale up testing, cuts to public health budget – it's all there.

The good, the bad and the ugly

My experience working in government, the Royal College of Physicians, and training in healthcare ethics, law and health management means that when I meet a patient on the wards, I am also thinking what it says about the wider system.

I am slightly reluctant to admit, I actually quite enjoyed pandemic medicine. I really, really enjoyed

being an A&E doctor in Manchester Royal Infirmary; I really enjoyed being a medical Registrar in big urban hospitals; and, once again, I felt useful when I volunteered to take on a 28 bedded Covid ward for 9 months. It also provided an insight into the response of the wider system. I think it is good that we're a bit kinder to people now, than when I started my house jobs. Sitting down and talking with doctors, nurses and the rest of the team, who had just been through the trauma of people dying from respiratory distress and lack of oxygen and feeling helpless, acknowledging their experience, and that the emotional impact they felt was normal, was extremely important.

As a journalist myself, I found that I was in great demand to write pieces in many newspapers, give interviews and off-record conversations about the stuff that was going on, because journalists were struggling to find clinicians or operational managers who would speak about what was going on. I think this was a big mistake. If we had allowed the cameras in, if we had allowed people to say how it really was, some of the anti-vaccine, conspiracy theory, anti-lockdown stuff might not have happened. The people who did speak out were GPs, because GPs are self-employed contractors; academics, or people who were in representative roles for faculties or Royal Colleges. And in Wales, they actively encouraged hospital clinicians to comment: a good move.

I don't do much investigative reporting, but I did send Freedom of Information requests to every trust in the country, asking if they had ever restricted Personal Protective Equipment (PPE), whether they had told staff of for using the wrong equipment, whether they had ever disciplined anybody for complaining about lack of PPE, and whether they were under investigation by the Health and Safety Executive for preventable deaths of staff. Only three trusts admitted to those things out of 130 replies, while the Doctors Association of the UK confirm that this was absolutely endemic: that people were being censured and having PPE denied. I think we have a real problem with a closed culture. I don't usually use words like betrayal, but I do in this case. Who is putting their neck on the block, going into work every day? Over 900 healthcare workers in England alone died. I lost two medical and one nursing colleague at my trust. People deserve better.

I would like to reflect on the experience in my own trust, although I am sure similar actions were taking place across the country. Not everything is the result of government decisions. If we on the front line are going to take credit for some of the things that went well, we also have to take responsibility for some of the things that didn't. Three weeks before any guidance came from the government we were already thinking, "What happens if we have 20, or 50, or 100 cases?" We changed the rotas; changed the bed configuration; decided which wards would be red and which green; prepared to cancel elective and out-patient work; redeployed staff to ICU.

We didn't have enough testing capacity: the UK only had 4-5,000 test available a day in March and April, and those tests often took days to come back; and of course a lot of people would start by testing negative before later being positive. This resulted in between one in four and one in five of all cases being acquired in hospital, partly because of the Covid prevalence in hospitals, partly because of lack of testing.

As we moved into summer, the lockdown sceptics, and the Covid denialists went to town saying, "The modellers have got it wrong again; the pandemic's over." Our local models proved incredibly accurate, compared to some other nations'. The Office for National Statistics Covid Survey, with half a million people doing testing every week, and the React study, are providing us with good national data that should be guiding

our response. Locally we saw the predictions play out. I was working on Christmas Eve and we had 70 Covid patients in our hospital: by the 29th December we had 150 and by the first week in January we had over 300, so we had a new ward full of Covid people every second day. We had our modelling about how many beds would be occupied by Covid patients, which proved very accurate, and we're still working on that basis.

We normally have 18 ICU beds – we got up to 39 in the end – of course the anaesthetists had to come in from theatre to staff it, space expanded into theatres, elective work was affected. National information to the media was that ICU occupancy was no higher than usual. Yes: because the beds have actually doubled! If you want to learn how not to do communication, look at our government's Covid response: it's been that ham-fisted. It must surely have played a major part in weakening compliance with infection control measures. I know, when the North-west was doing really badly, the local media could not get anything out of the local hospitals. They had been told very heavy-handedly to pipe down.

One of the most traumatised groups of staff were those who weren't used to working in intensive care, or unused to working with death and dying, who were required to go into these areas; also the ICU staff themselves, who were used to doing one-to-one nursing, having to cover three beds, supervising other people. There were never going to be the staff available for the Nightingale Hospitals as well, but we spent half a million pounds for each person admitted to a Nightingale hospital. There were only ever a thousand people ever admitted to them and we spent just shy of half a billion pounds.

We still hear arguments about how many deaths have been caused by Covid, itself, given that 90% of Covid deaths were in people who had comorbidities, but Covid played a big part

and, as you all know, we've experienced the highest excess mortality in the UK since 1942. And Sweden, which is often held up by the libertarians as a great example, had its highest excess mortality since 1919.

There has also been a change in where people die. There was a big spike in deaths in care homes, around March and April, in particular, before the change in policy, although many of the cases, contrary to popular perception, were not caused by discharges from hospitals, but were brought in by staff working at multiple sites and so forth. More people were dying at home, from cancer, strokes – conditions that would normally be cared for in hospital. They were staying away because they were worried that they might catch Covid in hospital – and they might have had a point.

What worked?

So, what strengths and weaknesses did the response highlight? I don't know if you're fans of 'The Producers'. "How could this happen? I picked the wrong play, the wrong director, the wrong cast. Where did I go right?" We survived. Good health systems, like Italy, France, Madrid, New York were also falling over under the pressure. It wasn't just us. The Germans have four times as many beds per capita as us, so they were ok, but where did

we go right?

The speed of the NHS response was incredible. The fact that within weeks of hearing about this we had plans to increase ICU capacity; reconfigure wards; change medical rotas; we avoided the same ICU overload as a lot of other countries and weren't having to turn a lot of people away from ICU. The Government, to be fair, did put in a lot of emergency money and, whatever else you might think of the Covid legislation, it was at least agile. There was great new capacity in step-down care. I've spent years doing front-line geriatrics and acute medicine and suddenly, for the first time in years, you had to delay making a referral to intermediate care until the discharge drugs were on the ward, otherwise the patient would be whisked away without them, although we are backsliding now.

We set up virtual wards. My own trust was looking after 100 people at home, with oxygen saturation monitoring and phone calls. General practitioners set up 'hot hubs' and rolled out most of the vaccination and online consulting. Clinical guidelines developed at speed as we found out more about the disease and its treatment, aided by big controlled clinical trials and the development of vaccines. Some of the clinical leadership from professional organisations was great.

What didn't?

I'm a great fan of Tom Lehrer (my wife is American), so I'm reminded of that line, "Apart from that, Mrs Lincoln, how did you like the play?" So what went wrong? Plenty. We've had to postpone lots of elective treatment. You simply could not be bringing patients in for elective surgery to hospitals where a quarter to a third of beds are occupied by patients with Covid. You might argue we've over-compensated, with huge waiting lists, more people dying at home, probably because of avoiding care. In the rush to blame GPs for the move to total triage for consultations, some people forget that the GPs were told to do that by NHS England and if they hadn't they would have been in breach of contract, the regulator would have come after them and, if they were sued because of a preventable death of a patient coming up to the surgery, they wouldn't really have a leg to stand on, because they would have been ignoring central guidance. I think there was a centrally-driven push to increase remote consultation and there were definitely access issues before – Covid has just tipped things further.

Infection control was found wanting. We shouldn't have been in the position that a quarter to a fifth of infections were acquired in hospital, and probably a fifth of the people who died. We didn't have anything close to the testing capacity we should have done, even within the acute sector. We didn't have enough PPE. Even with my beard, I was fit-tested for a mask. Fitted perfectly, but the mask never arrived, did it? We had local schools doing 3-D printing of visors, for instance. I think the NHS totally over-estimated the ability of care homes to cope with infection control. Having to isolate all the residents in their own rooms, and not bring them out to common areas and having staff who, themselves, were self-isolating. It was ill thought out. We didn't have social care people overseeing the decision-making at national level and it took several weeks before we had a functioning guidance for care homes.

We went and bought all this private sector capacity, but we only used about a quarter of it, for whatever reason. The Nightingales – a PR stunt. There's only 3,800 peace-time ICU beds in the whole of the English NHS. And they were planning to have 4,000 single-organ support ICU beds in an exhibition hall in East London. And across the rest of the country they did not have an inkling of what they would use them for.

Terrible, awful communications. It was

oppressive, it was suppressive, it was misleading, it was confusing. Watching Matt Hancock saying he'd thrown a protective ring around care homes at a press conference. How not to do it. It destroys public confidence and provides a cheap way in for conspiracy theorists if they can't even agree with each other what the figures are. And I think we know it is bad comms to just quote meaningless numbers – "We've sourced 7 million pieces of PPE this week" – what matters is, if I am a nurse, can I get the right PPE for me to do my job.

Staff getting sick, demoralised, burned out, dying, having to self-isolate. A lot of staff in care homes, like some NHS staff, just sleeping on site or in hotels. It's been quite traumatic.

The initial policy response was slow and complacent. The WHO was saying, get on with testing and isolating, and tracking: we didn't do it. Ignoring any opportunity to control our borders.

Croneyism – the National Audit Office and the Good Law Project have done a great job exposing that. Contracts going to shady providers and management consultants. Not just contracts by the way – key public appointments. Now, it's great that Kate Bingham is a venture capitalist with a pharma background and did a really good job with the vaccination roll out – fine – but by and large, no scrutiny of public appointments.

Then there was clumsy handling of the 'Do Not Resuscitate' decisions, and implied rationing of care, which is a perennial issue for the public – they do not trust the decision making: people putting the reason for do not attempt CPR as 'learning disabled' and neither the person nor their family even realising the decision has been made. I think we, as doctors, need to be a lot better at being quite explicit in informing the public about such issues.

Sailing into calmer waters?

So, what challenges do we now face? There are a lot of generic challenges that are nothing to do with Covid – workforce planning and retention is the big one. But also the changing nature of medical practice. We have become so good at preventing deaths in early and mid-life that the person who survives their heart attack in their fifties presents in later life with cardiac failure and peripheral vascular disease. That means we have to change to more of a focus on teams and systems, and less about heroic individualism and we definitely need more of a revival of generalism in primary and secondary care.

We also need to focus on inequalities and prevention. And prevention isn't just primary prevention of non-communicable disease: it's also when somebody is living with diabetes or hypertension that they have secondary prevention, to prevent complications arising.

But Covid hasn't gone away, with very high rates of infection in the community and 7,700 people in hospital. ICU capacity is not enough to give us the headroom for future waves; you can't train ICU nurses and consultants overnight; we've got to have better pandemic planning for the future and we shouldn't be waiting for a public enquiry before applying the lessons that are already so obvious.

AGM 2021

In my own trust, our plans for the next wave include:

- Minimise nosocomial spread, including limiting movement of patients between wards
- Protect our ability to meet non-COVID Urgent and Emergency care demand as well as accommodating our non-COVID medical patients appropriately
- Support staff health – facilitating annual leave, focus on work-life balance, professional psychological support and other wellbeing measures.
- We must not cancel all elective treatment again.

Are there reasons to be cheerful? We've got a bit more money; Amanda Pritchard has at least dedicated her whole life to working in the NHS and her management seems to be quite well respected. I think there are potential risks and benefits of the ICSs, but in every reorganisation, the benefits are never as great as the advocates suggest, and the risks are never as dire as the critics fear. Moving the organograms around without enough staff certainly won't improve the services. The NHS, culturally, is still there and there is still plenty of trust and support for the service amongst the workforce and amongst the general public. My greatest reason for optimism is the calibre of the people with whom I work. The junior doctors I work with are absolutely fantastic and professional, just as dedicated as ever.

References

[1] https://health.org.uk/publications/long-reads/nhs-performance-and-waiting-times
[2] https://www.instituteforgovernment.org.uk/explainers/general-practice-10-key-facts
[3] https://health.org.uk/publications/emergency-hospital-admissions-in-england-which-may-be-avoidable-and-how
[4] https://health.org.uk/news-and-comment/blogs/is-the-nhs-working-on-thin-ice-this-winter
[5] https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers
[6] https://data.oecd.org/healtheqt/hospital-beds.htm
[7] https://health.org.uk/blogs/nhs-winter-pressures-being-in-hospital
[8] https://www.kingsfund.org.uk/publications/critical-care-services-nhs
[9] https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2019_4dd50c09-en
[10] https://health.org.uk/publications/the-autumn-statement
[11] https://ifs.org.uk/publications/14552
[12] https://www.kingsfund.org.uk/publications/reforming-finances-NHS
[13] https://www.nuffieldtrust.org.uk/news-item/the-health-and-care-levy-what-does-it-mean-for-social-care
[14] https://health.org.uk/publications/health-and-social-care-funding-projections-2021
[15] https://ifs.org.uk/uploads/English-local-government-funding-trends-and-challenges-in-2019-and-beyond-IFS-Report-166.pdf
[16] https://www.oecd.org/coronavirus/en/data-insights/number-of-medical-doctors-and-nurses
[17] https://www.bmj.com/content/bmj/367/bmj.l6326.full.pdf
[18] https://www.nuffieldtrust.org.uk/files/2019-03/1553101044_heaj6918-workforce-briefing-190320-web.pdf
[19] https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review
[20] https://engagebritain.org/digging-into-the-numbers/
[21] https://cygnusreports.org/wp-content/uploads/2021/10/Report-Exercise-Alice-Middle-East-Respiratory-Syndrome-15-Feb-2016.pdf

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