DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

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JANUARY – MARCH 2023

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A View From The Chair

I do hope that everyone who was able to attend the recent Annual Conference and AGM of DFNHS felt that it had been worthwhile. Certainly, there has been plenty of positive feedback. For those who were unable to join the meeting, this newsletter contains summaries of the presentations: I hope you find them interesting and thought provoking.

What you have told us

The last couple of weeks has given time to reflect on the suggestions that were put forward by members as to our priorities for the coming year and these have been discussed further by the Executive Committee.

The NHS and the state of health of the nation is never far from the headlines. Various kites are being flown, often suggesting that the founding principles of the NHS are no longer practical or affordable. Those of us who believe that the principles are sound, but have been grossly undermined, whether by design or through incompetence, or both, over the past 30 years or more, need to seize the moment to argue our point at whatever opportunity presents itself and to be able to back up those arguments with accurate evidence. The presentations in this newsletter by John Lister and David Rowland are a good starting point and, for anybody unfamiliar with it, *The Lowdown,* edited by John Lister, is a great source of up-to-date information from across the country [1]. There is no shortage of evidence that could be useful to challenge ill-informed opinions in conversations with family, friends, colleagues, journalists or the man in the pub, but much of this information is scattered across different sources. DFNHS will be trying to bring this together into bite-sized chunks that might come in useful for such debates.

While one-to-one discussion can present an excellent opportunity to change people's minds, joining with other campaigners can multiply the impact powerfully. Our sister organisation, Keep Our NHS Public (KONP), is organised into local groups, whose members are usually deeply appreciative of support from people with clinical experience past or present, because of their insider knowledge of the system and the impact that service changes can have on patients. Dr John Puntis, DFNHS member and co-Chair of KONP, gave an inspiring account of their activities over the past year, including the People's Covid Inquiry, the report of which can be downloaded from the KONP website, as can the details of local groups, so you can see whether there is one operating in your area that you might consider joining or supporting [2]. KONP is also organising a national SOS NHS demonstration on 11th March, in central London, at which the DFNHS banner will be getting an airing, and probably in a number of other cities. Again, details are on the KONP website, but it would be heartening to have a significant DFNHS presence under the banner.

Another area that was felt worthy of discussion centred on the potential of more democratic workplaces.

The shortcomings of the current approach to work and subservience to our economic system is becoming daily more apparent in:

- its inability to act to address the ongoing climate and biodiversity catastrophes;
- the increasingly gross levels of inequality within and between societies, underlying increasing numbers of excess deaths and ill health;
- moves towards repressive legislation and support for authoritarian regimes in an attempt to quell dissent and preserve the

primacy of vested interests;
- the reversal of the brief recognition of the importance to wider society of 'essential workers', with current attempts to put them back in their boxes when they have the temerity to complain about their working conditions and the lack of resources to do their jobs properly;
- and the reliance on hierarchical management structures, with their tendency to stifle innovation unless it is directed from the top of the organisation, reducing people to cogs in the machine while at work and passive 'consumers' in their home lives.

Roy Lilley's presentation clearly emphasised the importance of the humanity that we can each bring to our work and the importance of giving people 'the time and space to do great things' and sharing their experience. A working group is being established to look at the potential of greater democracy in the workplace as a vehicle to address these issues [3].

The working group which has been exploring opportunities to make the disciplinary processes of the NHS less unfair, less discriminatory and more encouraging of raising safety concerns, presented a report on their progress, which can be found in this newsletter. They are now seeking to rally support for their proposals and would be keen to work with members who are willing to promote these thoughts through professional, academic and political networks. Please get in touch with Arun Baksi [baksi@baksi.co.uk] and colleagues if you are able to help, or if you just want to learn more about their ideas.

There was also an appetite to see whether we could make common cause with organisations representing the interests of our patients: they could be our most powerful allies and advocates for happy, well-trained staff, working efficiently in a well-resourced service. A more democratic working environment would necessarily include the voice of those depending on those services. It seems strange that we have not explored the possibility of such links before.

What we all can do

It is important that we replenish our membership, particularly with doctors in the earlier stages of their careers, so that we can draw from their understanding in the NHS (or NHSs) in all disciplines and in all the nations of the UK. It is the level of detailed professional experience that allows DFNHS to speak with authority and lobby to greatest effect. If any of you come across a colleague that you think might share our common values, please see whether they might be interested in becoming a member. If they are, let us know: we would be very happy to send them a copy of the newsletter, so they can get an idea of what we are about, together with an invitation to join. We will soon be publicising the Peter Fisher Memorial Essay Competition 2023, which is open to doctors in training, to raise our profile amongst colleagues at the beginning of their careers and, if you are able to offer any help in publicising this, please contact Peter Trewby (EC Member, trewbyp@gmail.com) or Alan Taman (Communications Manager, healthjournos@gmail.com).

We are very aware of the diverging health services in each of the four nations of the UK and our need to understand the impact of these different pathways of evolution on the services to patients and wider society. We would like to encourage groups of members to get together in each nation to discuss issues that are specific to their national service and would be willing to offer as much support as we can to get such groups off the ground. Chris Birt (EC Member, christopher.birt75@gmail.com) would like to hear from any members in Scotland who would be interested.

An increasingly important way of stimulating interest in our association is through social media. Our website and Twitter messaging are key elements and are most effective when there is a regular stream of stimulating and varied comment from as great a number of members as possible. If

anybody has a piece they would like to contribute, please contact Alan Taman, who moderates and administers our social media. Alan is also willing to teach you, if you would like to learn how to tweet to best effect.

Our health and social care services may be in a fairly dire situation at present. This has not arisen overnight and its resolution will take much longer than a single electoral cycle, which is presumably why our political representatives have so little appetite to set the NHS on a path to recovery from which they will only benefit in posterity. But there is still plenty to fight for and most of the public understand the importance of that struggle. They are listening, so now is the time to speak up for the principles of access to universal, comprehensive healthcare on the basis of need, not ability to pay, and to drown out the siren voices that would persuade them otherwise.

References

[1] The Lowdown.
Available at: https://lowdownnhs.info
[2] Keep Our NHS Public. Local groups directory.
Available at:
https://keepournhspublic.com/local-groups/
[3] Ferreras, I., et al. (2022) *Democratize Work. The Case for Reorganizing the Economy.* Chicago: University of Chicago Press.
Available from: https://bit.ly/3RpeMiY

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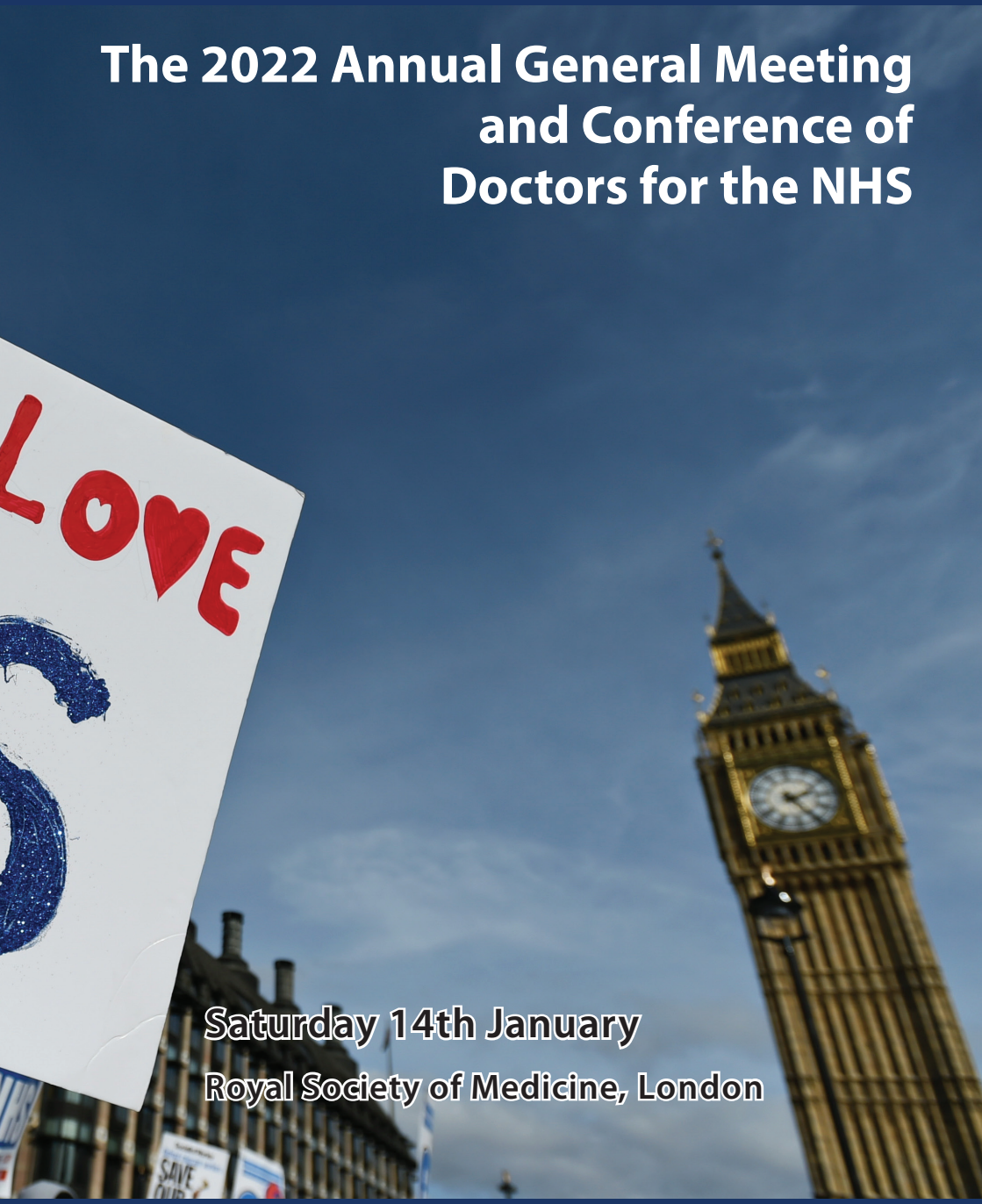
WE ALL
THE
NHS

The 2022 Annual General Meeting and Conference of Doctors for the NHS



Saturday 14th January

Royal Society of Medicine, London

AGM Reports

Opening address: Colin Hutchinson, Chair

[All of the Officers' reports can be downloaded from https://bit.ly/3H5fw8f]

The decision to postpone the Annual Conference of Doctors for the NHS last October, due to industrial action on the railways, is a minor example of the turbulence engulfing the UK and, in particular, its public services. Your Chair's natural state is one of relentless optimism, but he is finding this increasingly difficult to maintain in the absence of fresh ideas to meet the challenges we face as a nation and a species, and no discernible political will to implement any proposals that don't deliver quick wins inside one parliamentary term. The days of 'building back better' and 'levelling up' have been replaced by a return to the failed austerity policies and increased inequality that have landed us in this mess in the first place. 'When all you have is a hammer, everything looks like a nail.'

DFNHS exists to bring together doctors who believe that access to high-quality healthcare is a fundamental human right and that the public service ethos and the aspiration to the highest standards of clinical care are far stronger foundations for a National Health Service than the pursuit of commercial profits. DFNHS exists to help members pool their expertise and experience to furnish evidence-based arguments to press for those principles to lie at the heart of UK policy.

It is only after you have finished working in the NHS that you realise how difficult it is to find out what is really going on within our NHS trusts and other organisations and the value of the first-hand experience gained through day-to-day work. Most members of the Executive Committee have retired from clinical practice. We have the ability to set current issues in context gained from lengthy careers and we have the luxury of time to lobby for the causes important to our members, but we are increasingly dependent on members currently in work to make sure that we concentrate on the issues of greatest priority and that we can support our arguments with strong evidence from the workplace. We would very much welcome details of such matters from individual members of their experiences, either as clinicians or as patients, so that our press releases can be based on real examples, rather than broad arguments. The contact details of our Executive Committee members are published in each newsletter. Don't hesitate to get in touch.

If we consider the priorities that members suggested that DFNHS should concentrate upon at our last AGM, they remain unresolved, despite efforts by the Executive Committee to contribute to the debate, backed up by numerous authoritative reports form well-resourced think tanks, including the King's Fund, the Nuffield Trust and many others. First among these priorities was workforce planning and staff retention. We have been calling for a workforce strategy for more than 7 years, when the signs of recruitment difficulties were becoming acute in a number of disciplines. As late as 12 months ago, the Government were fighting off any statutory commitment to anything more than one review at some point in the span of a Parliament. DFNHS lobbied in support of opposition (and Conservative) amendments to address this through the Health and Care Bill, including meeting with Justin Madders MP, who was then a Shadow Health Minister, but these and all other amendments were defeated thanks to the Government's overwhelming majority. We tried to encourage the media to look behind the rhetoric surrounding the Health and Care Bill, and its lack of solutions for the most pressing issues facing the NHS, together with

the risks of fragmentation and commercialisation in breaking up the NHS in England, but the war in Ukraine and the Westminster soap opera were so much more interesting to most reporters.

At least the mainstream media seem to have now realised that the NHS is struggling to retain staff and that this might have a bearing on the level of service it can provide. The current Chancellor can no longer pretend ignorance of the crisis, but we have yet to see the promised workforce strategy, and his failure to increase funding for Health Education England in his Autumn Statement, nor lift the cap on UK students in UK medical schools, provides little evidence of ambition to embark on a journey which will not deliver clear benefits in time for the next election. Similarly, there was no provision to increase the capital available to the NHS to repair or refurbish the buildings and equipment our colleagues and patients depend upon; nor to maintain the value of the Public Health Grant to help address the impact of the increasing deprivation affecting so many households and communities. The signal failure to 'fix social care once and for all', particularly through undervaluing the workforce and the continued mismatch between resources and need, has consequences that are being played out in every accident and emergency department and ambulance trust across the country.

The impact of the reorganisation of the English NHS into Integrated Care Boards is yet to be felt, as they are just getting established, but the Government's decision to require 5% efficiency savings from each ICB in their very first year severely restricts any positive impact: instead there will be a reliance on short-term cuts to services before whole services disappear for those who cannot afford to pay. The pattern of change will differ in each Integrated Care System and will of course be blamed on the ICB, rather than the Government. We will be relying on our members to alert us to issues of concern in their area, so that we can identify any worrying trends.

DFNHS has for a long time tried to emphasise the importance of continuity of care to patients with ongoing health problems, both from the point of view of patient safety and satisfaction and the efficiency with which care is provided, but also the reward that comes to the clinician of treating patients as individuals over a prolonged period of time. We are not simply technicians, nor interchangeable cogs in a machine. Executive Committee member, Dr David Zigmond, has written compellingly on this topic, but it is important that we all raise this issue at every possible opportunity. It was good to see the importance attributed to continuity of care in the Fuller Stocktake, commissioned by NHS England and published in May 2022, but have seen little evidence yet of this being prioritised by health commissioners or providers. We will continue to emphasise its importance in retention of clinical staff, even though it also imposes obligations on clinicians to make themselves available when patients need them.

Members also agreed that we should continue to oppose excessive specialisation where this is to the detriment of clinicians developing their broad general skills, particularly during the early stages of training. This is an argument that needs to be played out within each medical royal college, professional organisation and appointment committee. The loss of confidence in treating a broad range of patients leads to unworkable on-call rotas, undermines services in rural communities and produces inevitable centralisation of services within 'centres of excellence' inaccessible to many of our patients. The generalist with a special interest must surely still have a firm place in the NHS. Again, detailed examples of service reorganisation from members would be very useful in illustrating our arguments.

The devolution of health matters to the individual nations of the UK inevitably results in divergence of policies in each nation, although the funding

envelope is largely determined in Westminster and policy in England has a major influence due to sheer size of population and economy. So far, there seems to be little appetite from Scottish members to get together to explore the particular issues playing out north of the border, although it would be very interesting to compare and contrast the two systems and their effectiveness. DFNHS would be very happy to support such meetings, but they would need to be driven by grassroots support from Scottish members. We would encourage suggestions from members in each of the nations for ways in which we can increase our relevance to them and Executive Committee Member Dr Chris Birt would be particularly interested to hear from Scottish members.

DFNHS was never set up to address terms and conditions of service, so is not seeking to compete with the BMA or Doctors' Association UK, and there is no intention to change our remit. We are, however, very concerned about the unfairness and injustice in the way that disciplinary processes are implemented in the NHS, including the adverse effect this has on patient safety. Executive Committee Members Dr Arun Baksi, Dr Malila Noone and Dr Helen Fernandes have been particularly involved in lobbying for change to the processes around the decision to invoke disciplinary procedures and the way in which those are pursued. They have had notable successes, such as gaining the support of our current Chancellor of the Exchequer (see page 25).

There are many organisations with objectives that align to a greater or lesser extent with DFNHS. One of our most important partners is Keep Our NHS Public (KONP). We have a place on the Steering Group, which brings together valuable experience from across England. I attend most of these meetings and try and ensure that our voice is heard where appropriate. I repeat my previous call to members to make contact with their local KONP group. They are usually very appreciative of the additional insight and support that can be provided by NHS insiders.

A significant proportion of your subscription is channelled in support of various good causes, agreed within the Executive Committee. This year, donations have been made to KONP, to support their campaigning work including publication of their People's Covid Inquiry; the Centre for Health and the Public Interest, which carries out detailed investigation of high quality, including into the risks of the 'independent' health sector, featured in a recent edition of Panorama; and the Good Law Project, which has taken on a number of cases, including questioning the lawfulness of the process of contract awards for personal protective equipment preferentially through a VIP lane. We would welcome discussion of future donations and the process by which those are agreed.

Obviously, quality is more important than quantity, but the more members that we have, the greater the income from membership fees and the more we can support such work. A larger membership also increases our ability to gather information and use it in campaigns and increases our ability to influence decisions that are being taken. Our membership is showing slow but steady attrition, largely due to the ravages of time. Part of the thinking behind the annual Peter Fisher Memorial Essay Prize was to increase awareness of DFNHS and hopefully membership amongst doctors in training, which has occurred, but to a rather limited extent. I have already referred to the importance of recruiting more members who are working in the NHS and would ask all members to try and encourage members of the profession, whether colleagues, friends or family, to consider joining. We can provide additional copies of the newsletter for them, on request, so that they can get a flavour of the organisation and if you have any suggestions as to how we might raise our profile, or otherwise boost recruitment, please discuss them with a member of the Executive Committee.

Similarly, we would be keen to consider any

nominations, including self-nominations, for new members of the Executive Committee, before or during the AGM. Meetings are held every couple of months and are on-line.

The concept of the NHS has been questioned since its founding, but increasingly this year, as the impacts of austerity policies and successive political 'reforms' have fed through to worsening patient experiences. There is a mass of good quality evidence to explain why the performance of the NHS has worsened over the past 12 years – that it is not the model that is at fault, but the way in which it has been mismanaged, whether deliberately or through incompetence or neglect. It is frustrating to hear the same prejudices and falsehoods repeated by commentators and politicians. DFNHS needs to ensure that all members have access to detailed information from reliable sources that can be used to challenge such assertions, whenever the opportunity arises, and that we continue to try and influence political thought and public opinion through the various channels of communication to which we have access. It is a mystery why there is not a greater level of popular anger than is apparent currently, but a dull acceptance that this is all inevitable. We need to ensure that any discontent is directed appropriately and is not a vehicle to support experiments into a two-tier health system.

The principal reason for which DFNHS was founded was to demonstrate professional support for the foundations on which the NHS was built. That support will be vital to its survival. Now is the time for us to come together, pool our resources, our experience and our ingenuity and contribute as skilfully as possible to the rebuilding of the NHS as a service in which we can, once more, take pride. Now would be an excellent time to get more involved in the activities of DFNHS, so please get in touch and we can talk it over.

Treasurer's Report: Peter Trewby, Treasurer

Summary

Total amount in feeder account was £5364 compared to £8553 last January [this now stands at £6369 after AGM payments were recevied] and £3500 in our current account. Our principal outgoings during the past year have been: (1) donations to KONP, CHPI and the Good Law Project (£1000 each), (2) £2600 "deposit" paid to secure the Royal Society of Medicine for our AGM, (3) magazine costs (around £750 per issue) and (4) Alan Taman's fee (£12,000 per annum). Subscriptions this year are down from £22,773 in 2021 to £20,661 due to a reduction in the number of subscriptions.

Figures 1 and 2 show our historic balance over the past 5 years and our balance over the past 12 months.respectvely. .

Subscriptions

Since our last AGM we have "lost" 52 members of whom 7 sadly have died, and 45 have not replied to at least two letters and emails or advised firmly that they wish no longer to be a member.A further 32 are

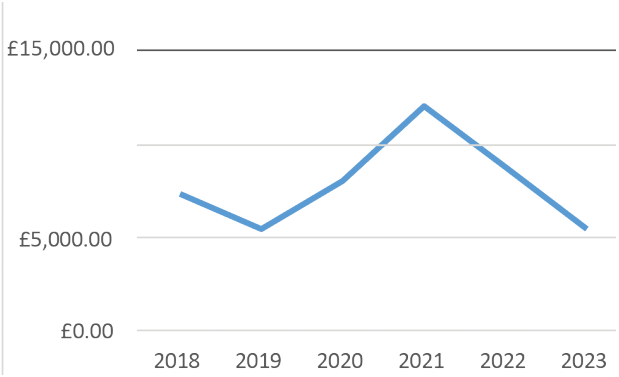


Figure 1 Historic feeder account balance Jan 2018-23

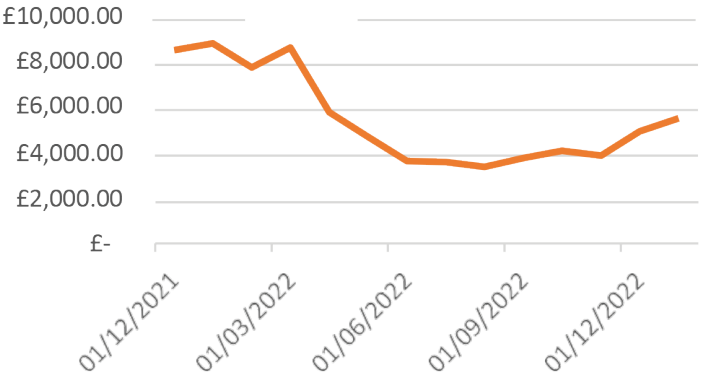


Figure 2 This year's balance, January 2022 - January 2023

being actively pursued for non-payment.During the same period we have only acquired 2 new members and no trainees. Current number of members is 583.

£700 Essay Prize

The title this year was: "To what extent are compassion and commerce compatible in healthcare?" 24 submissions were received this year compared with 79 last year but many have been of excellent quality. Submissions were marked by Colin Hutchinson, Morris Bernardt, Alan Taman and Peter Trewby. Winner, second and joint thirds were agreed. Suggestions for next year's title were invited from the audience and submitted to EC for consideration. Audited accounts for year ending 30 June 2020 were available at the meeting.

2022

In summary

Because of a reduction in subscriptions, there is only a small amount of money to be donated at the moment perhaps £1-2000 at most. We have agreed to drop the magazine back to quarterly and we continue to seek ways of raising our profile and reducing the decline in our membership numbers. 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 NHS now undeniably faces its greatest danger since it was formed. A dogmatic assertion that the NHS 'has had enough money' and 'is not facing imminent collapse' is prevailing in government. Despite the now unified voices of the Colleges and the BMA joining us in crying out that our NHS is so close to collapse and lives are now put at risk so commonly that not admitting that massive and systematic investment is needed is close to delusional.

The four 'big demons' for the NHS remain the increasing times people are having to wait, lack of workforce planning, under-investment in staff, and staff vacancies, all of which are related and – with the fifth related danger of poor social care – complement each other to yield the dystopian reports we are now seeing. People having to wait for days in A&E even if they can get there; people simply unable to get a GP appointment and resorting to self-treatment or putting up with suffering instead; colleagues resorting to strike action out of sheer despair; and others leaving the service because they simply cannot carry on. We now see the emergence of the very 'two-tier' health service we campaigners have been fighting and warning against for years, as people pay for what they can out of desperation, often going into debt to do so. A cost of ailing crisis to match the cost of living one. Privatisation continues apace, often on this 'micro-scale' of individual worry as much as through large-scale contracts and fragmentation on an organisational level.

What this means for Communications

Last year we advocated more coordinated action with other campaigning groups. This was facilitated by closer working for communications with Doctors' Association UK for common concerns (a liaison which continues on an informal basis), and more press coverage did result. This should continue, by considering working with other groups on the areas of concern described above. We already have good links with the established grass-roots organisations nationally such as KONP and We Own It. The current crises in the NHS have now become much more noticeable and the public and our colleagues need health campaigners to continue to fight for the NHS. We possess a perspective founded on long years of clinical experience which other groups, the media, and the public recognise. That is our 'USP' and that continues to be where we derive the authority and conviction of our messages from. We need to choose where we are going to focus. Picking our battles has never been more important nor the stakes higher.

Media and other channels

DFNHS continues to receive regular enquiries from the national press. Over the last year we have been quoted in the *Guardian*, *Independent*, the

Sunday Post in Scotland and the *Observer*, as well as approached by the BBC and LBC. Opportunities to comment will unfortunately be many over the coming months and it would be worth while deciding what our three or four 'key messages' might be so that these can be advocated regularly. We have good national contacts through which to do so.

The newsletter changed to bi-monthly and was well received, with an increased contribution from external authors. However, with distribution costs increasing it has been decided to revert to quarterly issues but to focus on increased pagination (32-36 pages as opposed to 20-24 per issue) and more articles from key authors outside the organisation. So members get more to read, albeit slightly less often. The website will have more blogs on a wider range of topics, and members are invited to send in articles for posting or to talk to myself about doing so.

The social media streams have continued to increase slowly in popularity. There remains scope to develop these more and this remains a priority. More volunteers would be very welcome and I will gladly support anyone who offers their time. With more help we can then post across several platforms (eg Instagram) more effectively.

Recruitment remains a concern. We do not face large-scale disaffection but as for any organisation we cannot continue indefinitely without more new members to replace those lost. One suggestion is that by changing to target doctors just reaching the end of their specialist training, DFNHS should be able to persuade more people of the need to join. Our membership remains largely Consultant level but an increasing number are retired. Doctors in training, although many are concerned about privatisation, are often faced with more pressing problems related to their early careers and life stages. So by targeting this 'mid-level' group, we aim to recruit people just as these early-career concerns are being surpassed. This is perhaps one way of addressing recruitment but there will be others and all suggestions will be welcome.

Most of all, we need to focus on what we should aim to do over the coming months, and even though there will be many more areas of concern we could address it is now important to be focused. AGM remains one of the best ways of voicing ideas – though anyone is welcome to make suggestions via the newsletter or to myself at any time. The fight is now at a critical stage and DFNHS has an important part to play.

Plans for the Future

Members suggested the following key points for consideration and action by EC.

1. Meeting with Wes Streeting, perhaps by approaching him as an alliance of campaigning organisations.
2. Co-posting Twitter tweets across other platforms such as Tik-Tok.
3. Contacting senior Specialist Registrars, people who were already showing an interest in management.
4. Compiling accurate information about the NHS's position, which was currently dispersed, eg over poor capital investment for the NHS, or the mis-spent PPE/Test & Trace monies.
5. Arranging an interview with the Public Health Minister for Scotland.
6. The breaking down of communities of colleagues through scaling up of healthcare organisations, especially in general practice, needs to be emphasised.
7. The anti-NHS narrative is growing in strength and needs to be countered with robust messaging. Again, strong evidence is available to do this and needs promoting.

2022

Political choices, not a lack of money that could be spent, were causing the problems.

Further responses from members are invited by email to Alan (healthjournos@gmail.com) who will collate them and forward to EC.

Election of Executive Committee

Mike Galvin was elected on to the EC.

Keep Our NHS Public Report

[This is an abridged version of the full report, which can be downloaded from https://bit.ly/3H5fw8f]

John Puntis summarised this for the meeting.

John thanked the group for its support of KONP. KONP remained busy and was being more effective.

The Peoples Covid inquiry had taken up a fair amount of time and the Report was now being widely circulated. KONP had helped set up the NHS SOS coalition and this continues, with national demonstrations occurring last February. Health Campaigns Together had now been incorporated into KONP. KONP had had more appearances in the media this year. It had established the End Social Care Disgrace campaign and had established working groups on integrated care systems, data sharing and security and a working group looking at general practice. Members were encouraged to look at the reports from these groups on the KONP website. There had been some success in looking at Pathfinder Hospitals.

KONP had continued to work closely with We Own It and 999 Call for the NHS. It had requested meetings with the health leads in the opposition parties. KONP remained active locally, with 70 groups and about 1 600 members. Colin Hutchinson stressed the value of doctors joining with other campaigners to strengthen the campaigns with their experience of working within the NHS. The KONP national team remained relatively small and KONP was now a limited company, employing people directly. Financial reserves were currently under more strain than recently. John reminded the meeting that individuals committing to regular payments would be appreciated.

Speaker Reports

Why the NHS is in its deepest ever crisis and why only extra cash can save it

Dr John Lister
Compiled by Andrea Franks

John has been a journalist since 1975, and specialised in health policy since 1984. He achieved a PhD in health policy in 2004, and has since authored and co-authored books on global health policy and England's NHS (most recently *NHS Under Siege*, 2022). He has worked with health unions and others on a wide range of projects including mental health, long-term care, cutbacks and reconfiguration plans. He was a founder member of KONP and of Health Campaigns Together, and in 2019 with Paul Evans of NHS Support Federation launched and co-edits *The Lowdown*.

A recent poll shows that even 73% of Conservative voters now blame the Government for the state of the NHS. Whoever do the others blame? In spite of their name, by continuing austerity the Conservatives do not appear to want to conserve anything, even the country's most popular and universal public service.

The party quotes 'record spending' on the NHS. While this may be true it relates only to the nominal cash increase almost every year since the NHS was formed: spending now is insufficient to improve anything or to meet demand, and inflation makes this worse.

A recent comparison in the *Financial Times* compares UK capital spending on the NHS with that of comparable countries. It was low during the Thatcher/Major period up to 1997, when no new hospitals were built. Spending rose steeply with New Labour's decade of investment, but fell sharply from 2010 to levels well below other countries.

Funding decisions have an impact. NHS waiting lists rose under Thatcher and Major, dropped rapidly under New Labour but have shot up again since 2010. A+E waits have increased, while avoidable deaths, which had been falling, are now above those of comparable countries.

The average increase in spending since the mid-1950s up to 2010 had been about 4% each year to cope with increasing pressures. Mrs Thatcher broke this consensus, and without New Labour's increased spending we would no longer have an NHS. Recent promises of extra funding are too little, too late: there is now a cumulative gap of about £30 billion a year, affecting both capital and revenue.

We can now see the consequences. A+E delays are the worst on record, with only 65% of patients treated within 4 hours in December 2022 and even fewer (49.6%) of the most serious cases. 54,532 emergency patients were delayed for 12 hours or more in A+E after a decision to admit, 10,740 higher than in October 2022 which was previously the worst on record. 12 hour trolley waits have increased 2,223% since October 2019, before the

2022

pandemic. If this does not improve (and there is no sign of a change) nearly half a million patients a year will suffer these delays. Ambulance response times have greatly increased. The target time to reach a 'category 2' 999 call (for instance heart attack or stroke) is 18 minutes, but the average in England is now 90 minutes.

This is not happening because of poorly performing ambulance services, but because the hospitals cannot process the patients quickly enough once they arrive. A+E attendances have actually fallen by 18% since 2019, with type 1 attendances, likely to need admission, nearly 25% lower. The problem is lack of capacity; insufficient hospital beds, inadequate care in the community to allow patients to be discharged – and lack of staff to reopen beds which have been closed since 2010. 133,000 NHS posts are currently vacant, 10% of the workforce, and this number is rising.

Bed numbers have been reduced since 2010 and the actual capacity has fallen further. In the last quarter of 2022, 19,000 (21%) of the 92,000 occupied beds were filled with Covid patients or with patients well enough to be discharged but without social care support. On January 4th, more than 96% (a new record) of 95,844 general and acute beds were occupied. Many people should be discharged to their own homes with adequate community support, but the investment needed for social care is just not there.

Without beds and staff even cancer care targets are missed. The two month target for starting cancer treatment has not been met since 2014 and this is getting worse. Similar problems in mental health result in excessive delays for treatment and often long journeys to find a bed.

How about doctors? GPs are constantly criticised by right-wing politicians and the media and even Wes Streeting has joined in. Although the Government quotes a marginal increase in numbers, the figures show clearly how the number of FTE GPs per 1000 patients has reduced. There are now more patients per practice, but fewer practices. Some have closed and others have merged into larger practices which may be less local and convenient for patients.

Although there are fewer GPs, they have given record numbers of appointments, 36 million (more than ½ the UK population) in October alone, with ¾ of these face to face. Those, often in the media, who argue that GPs are not pulling their weight, do not appear to know what GPs are actually doing.

Staff vacancies have risen significantly, up 29% in a year, as staff feel demoralised and burnt out and seek better paid and less stressful jobs, but this leaves unsafe levels of staffing and puts more pressure on those who remain.

Lack of capital investment is a huge problem and since 2010 has fallen well below that of comparable countries. '40 new hospitals' have been promised many times, although less than £4 billion has been allocated for this programme and their size has been revised downwards. Another 8 new hospitals were promised, and 127 Trusts spent a great deal of time preparing bids to be one of these, but it seems unlikely that any of them will ever be built.

The maintenance backlog has risen from £6 billion 2 years ago to over £10 billion now, and some hospitals built in the 1970s are actually falling down. In King's Lynn Hospital, for example, the concrete ceiling is held up by 2200 metal props and there are evacuation plans in case it starts to collapse.

Private sector spending in the NHS has gone up, with a 25% increase in 2021-22 to £12 billion, because of the deal, rarely actually used, to use private hospitals for NHS patients during the pandemic. These windfall profits for the private sector may not continue because some integrated care boards are planning to bring the work back in house to save money.

There is no light at the end of the tunnel. The 42 new integrated care systems (ICSs) had

been told to deliver £5 billion 'savings' this year to balance their books, before energy costs and general inflation shot up, and without allowing for increased staff pay. It was assumed that Covid would now have finished, but waves are continuing and 7,500 beds are still filled with Covid patients. In October 2022 NHS England increased the 'savings' target to £12 billion up to 2025, demanding record 'efficiency savings' of 2.2% per year.

Integrated Care Boards are already falling behind with this, so problems will build in 2023-4. Campaigns must focus on funding and defence of services. That's why the SOS NHS coalition demands at least another £20 billion immediately to begin to repair the damage.

Right-wing politicians and the billionaire press, particularly the *Telegraph*, delight in every failure of the NHS while completely ignoring the causes over the last 12 years – for instance Allister Heath has stated 'The NHS is dead and it's dragging the rest of the country down with it'. Their hostility to the NHS is matched only by their obvious ignorance of the systems they promote as alternatives.

If they think the NHS is so hopeless, what do they want instead? Most of those wanting a more privatised system have distanced themselves from the US system based on private insurance, with its extravagant waste, fraud and inflated costs which leave huge numbers uninsured or bankrupted.

They generally favour other models which appear to offer universal coverage which is free at the point of use. A 2019 neoliberal manifesto produced by the parliamentary 1828 committee (Liz Truss is a board member) with the Adam Smith Institute condemned the NHS as 'deplorable' and advocated social health insurance similar to systems in, for instance, Switzerland, Belgium, Germany or the Netherlands.

Previous Brexit secretary David Davies last autumn called for scrapping the NHS as a tax-funded system 'because the NHS as launched in 1948 is out of date'. He advocated social health insurance, which would reinstate the failed system in place in Britain before the NHS.

Social health insurance started in Germany under Bismarck in 1883, but only covered some working men and not their families or retired people. Two years later, only 10% of the German population was insured, through 1,900 sickness funds. Even now over 500 different health funds are involved in the German system. In the UK in 1919, Lloyd George's National Health Insurance Act was passed. This evolved into the system used until 1948, by which time under half of the population had access even to primary health care.

Dr Christian Nimitz of the IEA claims that social health insurance systems have better health outcomes, but ignores the fact that Germany has for decades spent much more on health than the UK and now has over three times the number of hospital beds per thousand population as well as many more doctors and nurses.

The government claims record NHS spending, though much of this was squandered on ineffective Test and Trace and contracts for useless PPE. Total GDP varies, so the percentage of this spent on health is much less important than the funding per person, which is much higher in all the systems favoured by neoliberals than in the UK. Germany, for example, spent 46% more per head on health than the UK in 2019, Switzerland 58% more and Belgium 22% more.

As well as higher spending, however, there are more out-of-pocket costs for patients, such as in Switzerland where patients contribute 26% of total health payments, which falls disproportionately on poorer people. In Belgium, there are higher user charges for mental health and dental care than for acute care, and in the Netherlands the poor spend 20-25% of their income on health.

Social insurance systems, then, are far from ideal. The NHS is not, as often misleadingly stated, an

insurance system, but is paid for by general taxation which shares the risks and costs across the whole tax-paying population and not just those currently paying National Insurance. The NHS was the first system, and one of very few, to raise no user fees. This has, sadly, been eroded but is still fundamentally there. There has never been a qualifying period or the requirement to pay premiums.

Those advocating an insurance system want to 'share the burden and the opportunity' with the private sector, but the 'opportunity' is just profit and would not improve health care. Allister Heath of the *Telegraph* plays on his readers' seemingly boundless ignorance. He even admits that an insurance system would cost a lot more and advocates user charges and a mix of for-profit and charitable ownership, though wants 'a generous safety net' with more public as well as private funding. He would require the private sector to build more hospitals and capacity 'even if some of it occasionally lies idle' – which would be unpopular with the private companies.

The complexity and upheaval of changing to social health insurance, with contributions from workers and employers, would not be the way to save the NHS. Our current government would not include the protections which still apply to the poor and elderly in Germany in spite of increasing user charges.

Social insurance is not the answer to any of today's NHS problems. Such a system from 1911 was superseded by the NHS which was universal and more forward-looking. It allowed services to be planned on the basis of local need and accessed regardless of ability to pay, with national training systems for staff.

Only the Conservative right wing and neoliberal lobby groups want social insurance back. The NHS is the most civilised answer to the inverse care law – those most in need of care being least able to afford it – which has prevented any country having an entirely private system. All health systems require public subsidy and even Pinochet's brutal Chilean dictatorship was unable to privatise the whole service.

Health insurers prefer those least likely to make a claim, but the NHS covers everyone. In spite of all the years of Tory government and the ways New Labour wasted so much of the extra money they put into the NHS, we still have an NHS in which a large majority of services are publicly funded and publicly provided. It has not been sold off. Too many services cherry-picked by the private sector have been contracted out but the NHS pays the bills, and they could and should be brought back in-house when contracts expire. No private sector buyers would want to invest in the whole of such an underfunded and understaffed service in an unhealthy nation, when so few parts would be profitable; in any case even most Conservative voters would be against this. The current situation suits the private sector which profits from the wealthy and from patients paid for by the NHS and uses staff trained in the public sector, but does nothing which could not be done better by the NHS if given more resources.

The answer to the current crisis is not privatisation but increased investment to expand NHS capacity and workforce, which is the only way to have a fair, sustainable, universal and comprehensive system.

We must fight now to build a broad coalition, not just involving Labour and those on the left. If 76% of Tories think the Government is getting it wrong, we must try to involve some of them in campaigns as well, making ministers realise more damage to the NHS will affect their political support. If we fight hard enough we can hope to turn this around, otherwise we will lose the staff who can make it work before we can repair it.

It's been done before, it can be done again. Let's keep the NHS and keep it public.

How the growth of for-profit healthcare in the UK threatens to undermine the founding principles of the NHS

Dr David Rowland
Compiled by Colin Hutchinson

David is the Director of the Centre for Health and the Public Interest. He has been involved in the development of the Centre since its inception in 2011. He was a research fellow at the School of Public Policy, University College London, undertaking research on the Private Finance Initiative and social care markets with Professors Allyson Pollock and Colin Leys. He also worked with Professor Scott Greer on projects examining EU health policy, the management of the NHS and administration of Communicable Disease Control.

Thank you for the support DFNHS has given CHPI over the years. We are a small organisation and John Lister's address has reminded me how important that wider network is to our continuing existence.

Today I would like to build on some of the issues that John has raised, about the relationship between the NHS and the private sector and some of the trends we have seen over the last decade, since austerity has eroded many services, staffing levels and other resources which underpin the NHS.

I would like to consider three things:

1. Where have we got to with the growth of for-profit healthcare in the UK?
2. How did we get here?
3. What are the implications for doctors, patients and the founding principles of the NHS?

I would also like to echo John's point that this is only part of the problem. The main issues are to do with underfunding, but there are shifts in particular areas of provision which are beginning to chip away at some of those founding principles – the idea that healthcare should be provided on the basis of need, rather than the ability to pay.

Where have we got to?

So, to start with a few interesting facts, some of which may be partially influenced by the pandemic:

- In 2021, more hip and knee surgery was carried out on a for-profit basis than in NHS units, partially due to bed constraints arising from the pandemic.
- As of 2022, the majority of cataract surgery is now provided on a for-profit basis (both NHS and privately-funded care).
- Since 2014, overseas investors have invested over £2 billion in hospital facilities for the delivery of for-profit care in the UK, in contrast to the dearth of capital investment in the NHS.
- The vast majority of residential, nursing and domiciliary social care is provided on a for-

profit basis. 62% of care home residents are paying out of their own pockets. This is a recent shift, but part of a long-term trajectory.

- The number of people paying out of their own resources for hip surgery through for-profit healthcare has increased by 193% since pre-pandemic. Some of this could result from household savings accruing during the pandemic, but much may be due to desperation.

How did we get here?

1. The outsourcing of some NHS services to for-profit providers

This goes back to the creation of Independent Sector Treatment Centres and the introduction of 'Choose and Book', under which it was mandated that, if you visit your GP and they decide to refer you for elective treatment, the GP is required to offer a private hospital as an alternative to an NHS hospital. As a result, the main for-profit hospital companies now generate between 30% and 80% of their income from the taxpayer, and this is growing faster than provision in NHS providers (Table 1).

Table 1 Growth of volume of treatment (%) in the NHS and the private sector

	NHS funded and delivered growth 2010-18	NHS funded in private sector 2010-18
Outpatients	39	450
Inpatients	19	156

2. The state subsidises for-profit providers

Under New Labour, the government underwrote the risks of overseas investors, establishing Independent Sector Treatment Centres (ISTCs) at a cost of around £350 million. The growth of three of the largest current for-profit companies can be traced back to the ISTC programme: Ramsay Healthcare, Spire Healthcare and Practice Plus Group. This kick-started foreign investment in the UK healthcare sector, and continuing support has ensured that capacity is available now.

The for-profit sector is entirely dependent for its output on the NHS consultant workforce, operating on a freelance basis. The for-profit sector does not contribute to the initial or ongoing training of this workforce and does not contribute to any of the associated employment costs. The value of this 'free' input, largely provided by the tax-payer, is around £7.5 billion (based on 17,500 consultants working in the private sector with a training cost of about half a million pounds per consultant).

Because of this employment model, the state currently permits for-profit providers to avoid liability for any medical negligence claims associated with a consultant's poor performance. This was seen clearly in the Ian Patterson case, where private hospitals denied liability on the basis that they were simply renting him their facilities [1]. When things go wrong, the NHS provides a free safety-net for the for-profit sector, so they avoid the considerable costs involved if they had to provide it themselves (Table 2).

Interestingly, during the pandemic there were 6,600 transfers from the private sector to the NHS, so, far from helping the NHS out of a jam, the arrangements were working in the opposite direction.

In the first year of the pandemic the government granted the for-profit sector £2 billion to cover their full operating costs, pay for staff, full indemnity

Year	Average length of stay in NHS hospital (Days)	Patients Transferred 2013-14	Cost of patients transferred 13- 14 (£m)	Patients Transferred 2014-15	Cost of patients transferred 2014 -15	Patients Transferred 2015-16	Cost of patients transferred 2015 -16	Total £m
Elective	17.96	1,898	£35.8m	2,134	£40.2m	2,610	£49.1m	£125.1m
Emergency	11.81	4,328	£29.2m	3,341	£22.5m	3,070	£20.7m	£72.5m
Other	17.96	1,802	£18.5m	1,979	£20.3m	1,753	£18m	£56.8m
Totals	17.96	8,028	£83.5m	7,454	£83.1m	7,433	£88m	£254.5m

Table 2 Estimated cost to the NHS of treating patients transferred from private hospitals 2013-16

cover and supplies for capital expenditure, but they actually delivered less NHS care than they did the previous year, despite the claim that they were supporting the NHS [2]. The Competition and Markets Authority had previously noted how the NHS had enabled the for-profit sector to survive the impact of the 2008 financial crash.

Exploiting the 'managed decline' of the NHS

International investors are aware of the opportunities that are opening up in UK healthcare:

> **"Continued structural pressure on the NHS will ... increasingly necessitate the use of the most efficient providers and ... is likely to lead to more outsourcing to the private sector. If not, we still believe the private sector will benefit as individuals are increasingly forced to dip into their own pockets to fund care."**
>
> *(J P Morgan Cazenove, 14 February 2017)*

This thinking underpins their investment activities, including £1 billion recently invested in the US-owned Cleveland Clinic, which has opened in Central London. Across the country, £2 billion has been invested since 2014, in ophthalmology, cancer centres and other hospital facilities.

Implications for patient safety

There are known systemic patient safety risks associated with the for-profit sector's business model. These have been known at least since the inquiry into the activities of Rodney Ledward which reported in 2000 [3]. Financial incentives and the freelance employment model led to poor governance and oversight contributing to the provision of unnecessary and harmful treatment. These risks have been cited in five coroners' inquests and reports from the Care Quality Commission (CQC) and the Commons Health Select Committee, but have been ignored for a very long time without any attempt to address the underlying factors nor even to implement the fairly weak recommendations from the more recent Ian Patterson inquiry. It seems the government is content to let it continue.

The CQC describes the Consultant as the main customer of the private hospital. They bring most of the work into the sector and, if they bring in more work, whether necessary or unnecessary, they are responding to the financial incentives. There may be a strong imperative for the private

company to perhaps look the other way, as has been seen time and time again in governance and oversight cases. This is often attributed to a 'rogue surgeon', but this is strange terminology. We never hear of a rogue bus driver or a rogue airline pilot. There was of course the rogue captain of a cruise liner, but in most sectors we don't attribute such failings exclusively to a rogue individual. It is not so much the rogue surgeon that is the problem, but the governance and oversight arrangements, the financial incentives and the structure that permits people with an unclear idea of the purpose of medicine to commit significant harm. It is important to remember that this is baked into the business model of many private hospitals.

The second issue concerns Resident Medical Officers (RMOs) responsible for post-operative care of patients at private hospitals. There has been a recent BMA survey of RMOs and a good File on Four documentary on Radio 4 (11 October 2022, but still available on BBC Sounds) They are usually junior doctors, supplied by an agency, after recruitment from outside the UK, particularly from Africa and Eastern Europe. RMOs were found to be working 168 hours a week, under employment conditions described as 'borderline slavery'. They are obliged to opt out of the European Working Time Directive, which is a safety directive as much as anything, without sufficient support from senior doctors and without being given the opportunity to understand the healthcare system within which they are working, prior to taking up their posts.

Implications for patients – hollowing out of NHS services

Because less complex procedures are being outsourced to private providers, there is the potential to leave NHS departments treating more complex patients, with fewer staff, at higher cost. For NHS ophthalmology departments to remain financially viable, they need to deliver lots of cataract operations. Without this income, they struggle to provide round the clock emergency services for sight-threatening conditions and treatment for a wide range of less common, but serious, conditions. It also means that in areas where new for-profit cataract services are being set up, they can attract NHS ophthalmologists: they get paid more, with less stress and they only need to focus on routine types of work.

Such a shift is beginning to hollow out NHS services and can even undermine the finances of a whole NHS hospital, as income from elective care subsidises loss-making complex services, such as maternity.

There is also the potential for 'middle class opt out' as a result of growth of out of pocket payments due to 'managed decline'. The consequence, over time, could be a residualised NHS and reluctance to support the taxation required for a universal, comprehensive service.

Implications for doctors

A change in ethics and working practices is discussed in the CHPI report, 'Pounds for patients' [4].

481 medical consultants were found to have equity stakes in 34 joint ventures with private

hospital companies. 73% of these consultants were directly employed by the NHS. In some cases, over half the consultants in NHS oncology departments have shares in private hospitals. How is this permissible?

177 medical consultants were found to own equipment in for-profit hospitals. 77 were receiving a fee each time the equipment was used, so an incentive exists to provide as much treatment as possible. There has been a recent GMC case where an oncologist was referring patients for treatment that was deemed to be of very little benefit, using equipment that he owned, for which he then received payment.

Financial conflicts of interest are definitely increasing. The Professional Standards Authority proposes a cross-sector review of the effectiveness of current arrangements to address financial conflicts of interest among healthcare professionals.

What can be done?

Ultimately, the growth of for-profit healthcare, whether by active subsidy, or by managed decline of NHS services, is a political decision, but we need:

1. *Awareness* – the growth of for-profit healthcare in the UK, the consequences, with the safety risks, the poor value for money and the reasons behind it, are poorly understood by the public, the media and the policy makers.

2. *Regulation* – the very weak regulation of the for-profit sector could be addressed easily, but the government is extremely reluctant to intervene.

3. *Professional engagement* – the growth of for-profit healthcare can only occur with the support of the medical workforce. 17,500 consultants is surely not a huge number of people to convince.

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2022

Reforming disciplinary procedures in the NHS: a better way

Drs Arun Baksi, Helen Fernandes and Malila Noone
Compiled by Alan Taman

EC members Arun, Helen and Malila have been leading a campaign to reform disciplinary procedures in the NHS, which currently benefit neither patients nor clinicians. They summarised this for AGM.

Helen outlined the background to the disciplinary framework for maintaining high professional standards (MHPS) as it currently stands.

Established in 2005, its aim was to try to prevent the prevailing 'blame culture' in the NHS and give a framework for taking doctors through disciplinary investigations. This was supposed to 'delegalise' the system. In recent years this has been show to be failing. The 'Freedom to speak up' review [1] had highlighted the increasing conflation of safety concerns with disciplinary issues – blame the doctor, not the system. An imbalance in the workforce in relation to bias in disciplinary action has also long been recognised and there is deliberate misuse of MHPS by Trusts. The principles of natural justice, with adequate notice, a fair hearing, and the absence of bias and a requirement for clear audit should be apparent but many Trusts do not observe these.

An FOI request was sent to 140 Trusts in February 2021 relating to their MHPS activity (number of concerns, investigations, outcomes and ethnicity and gender of doctors affected). None of the Trusts responded with complete date (Table 1) and many used an 'S40 exemption' to withhold information.

Table 1 FOI responses from all (n = 140) trusts, February 2021

Responses	Number
No responses to reminders over 9 months	10
Refusal on basis of cost	14
Refusal as low priority	1
Responses promised but not received	12
Confidentiality compromised by low numbers data recorded as <5 or <10	21
Incomplete or limited data provided	73
Complete data submitted	0

Table 2 Headcount, gender and ethnicity of doctors by trust

	No of doctors per trust	Female (%)	BAME (%)
High	3752	64	79
Low	58	15	10
Average	715	43	42

Table 3 Types of formal MHPS investigations recorded 2015-20

Types of investigation	Conduct	Capability
Total numbers of doctors affected	910	90
S40 exemption applied to number of doctors affected	13	23

Table 2 shows the headcount, gender and ethnicity and Table 3 the outcomes of MHPS investigations where disclosed. Financial disclosure was very limited owing to a lack of clarity in what needed to be recorded then disclosed but individuals in communication with the authors had told them the typical costs were hundreds to thousands of pounds each. The data did show that BAME doctors are more often investigated and more likely to be referred to the GMC. Trusts are not keeping an accurate record of numbers of doctors referred to the GMC but it was apparent that BAME doctors were over-represented for all categories of complaint to the GMC other than where health was a concern and when a complaint was closed after an investigation. BAME doctors are more likely to be referred by the GMC to a Tribunal but then more likely to have the complaint closed on hearing.

It was clear that Trusts do not hold the information the MHPS requires them to hold, especially with regard to the financial costs of their actions. MHPS currently does not record disciplinary procedures properly and these are not audited or costed, and high levels of discrimination are indicated.

Malila described how managers were not acting fairly in disciplinary proceedings. She referred to the Chris Day case to illustrate this, showing how the Trust Chief Executive had lied on oath and the Communications Manager had deleted all of his e mails prior to the hearing. These actions had ensured a finding of unfair dismissal was made far less likely. She referred to Jeremy Hunt's observation that the system itself was rogue, and broken, and there had to be a fundamental change to that system if improvements were to be made.

Arun gave a brief summary of how disciplinary proceedings were carried out prior to 2005. Originally a panel of three people had held these and this seemed to work. This had changed in the seventies, where a large number or suspensions had resulted in the establishment of MHPS. This had a large number of faults and is now widely

misused. The effect of these proceedings on individuals was grave. Some doctors had been suspended for years.

The aim of the proposal was to improve internal processes for Trusts: an independent elected scrutiny panel with its own statutory powers. The panel (7 senior doctors, 4 senior nurses and 3 Non-Executive members) would rule on whether further disciplinary action including referral to the GMC could be carried out. Management would need to refer any disciplinary matter to the panel and all doctors would have the right to approach the panel. The panel would be required to produce reports monthly and annually.

This should yield a fair and efficient system, a palpable change in culture, reduced referrals to the GMC and an accurate record of activity and cost. The panel could also function as the local guardian of professional standards. The same principles could be adopted to all healthcare staff.

This would require parliamentary action to put in place so gaining the agreement of MPs is critical. **Arun appealed to members to write to MPs and asking them to support the proposal [you can see the proposal on the DFNHS website: https://bit.ly/404ltuY].**

Questions from the floor

The authors were asked whether further analysis of the BAME data might reveal more detail about particular ethnic groups. They agreed this could probably be undertaken, but on balance they felt that the main focus of the work should remain changing the system itself through their proposal for elected panel members. The authors were asked how much the GMC were engaged on local resolution, and whether the Health Services Safety Investigation branch were likely to be interested. Arun pointed out that the GMC had told the authors they had no power to act at a local level. David Zigmond pointed out that GMC referral had changed in his professional career to be one of 'compliance', where not fitting in or speaking out against the system could result in a referral. Colin Hutchinson agreed that there needed to be a better way of resolving difficulties about personal performance and that the disciplinary process must be one that was less about punishment.

Reference

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AGM

The Paul Noone Memorial Lecture: How to improve the understanding of the general public, our media and our politicians, of the key issues facing today's NHS challenges

Roy Lilley

Compiled by Colin Hutchinson

Roy is one of the most influential health commentators in the UK. He has been a policy advisor, a visiting fellow at Imperial College London, helped set up the Health Services Management School at Nottingham University and was a founder of what has become the NHS Confederation. Roy's e-letter has gone out several times a week for more than 10 years and reaches some 300,000 people, through *nhsManagers.net*, and links to a wealth of information.

I think it's true to say the NHS is going through a bloody awful time. We have spent the last 3 years looking at a screen: it's good to meet face to face again. Thank you for all the NHS has done during this horrible time. It may sound hollow, but 'Thank you' is something we might not say often enough.

Covid led to a lot of human tragedies, but also brought out the best in a lot of people. It changed how a lot of things are run and how we address our problems, and it certainly brought out the best in a lot of our young people, who are in the front line of healthcare. And there's no better example of that than the nurses who were asked to volunteer, in their third year of training, whether they would like to work on the wards ... and all of them did.

But it was a challenging time, and a time that I think we can be very proud of. Amanda Pritchard, the black widow who is in charge of NHSE, is in *The Times* today, which is pay-walled and read by almost nobody, and says, "It is a difficult time", so it's official.

Now some of you may know that I write an e-letter, nhsManagers.net, which is free to subscribe to, and readership has gone from 25 readers to 300,000. God knows why people read it – I'm only glad they do. I thought I would read for you what I've written for Monday, because I think it sets the tone for what I want to say next.

We don't

I thought we'd start with our old mate, Jorge Agustin Nicolás Ruiz de Santayana y Borrás. He said something that I thought was worth repeating. We know him better as the philosopher, George Santayana and for giving us the phrase: 'Those who cannot remember the past are condemned to repeat it.' – from his 1905 book, *The Life of Reason.*

It came to mind after a week of listening to exhausted NHS workers, on the airwaves, telling us how dreadful things are in the NHS and how 'they've never seen anything like it.'

They probably haven't, but I have. I can tell you about the spike in flu cases, part of the problem we have today, in the winter of 1999-2000. The NHS was predicted to collapse and almost ground

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to a complete halt. Thousands of people had their operations cancelled and at one point there were only two intensive care beds vacant in the whole of England. Ambulances ferried really sick people around, to wherever there was a vacant bed. Bed occupancy was over 90% and in some intensive care units it was 100%. The numbers showed bed occupancy and often showed more than one patient to a bed. Such was the way the NHS counted things! It's different now, of course.

Sydney Flu, as it was called, swung a wrecking ball through the NHS and it prompted Tony Blair to launch a national plan 'to save the NHS'. (By the way, Keir Starmer, currently fiddling about with NHS 'reform', would do well to read this [1], and also consider how Blair got waiting lists down to single figures.)

The National Library of Medicine reported, '...low uptake of influenza vaccine, a shortage of nurses, unrealistic expectations of patients, an already high occupancy of beds, and the unfortunate timing of outbreaks of both influenza and meningitis over the new year holiday brought the NHS to its knees last week.'

The Public Health Laboratory Service warned, '... that vaccine uptake in 1996-7 was only 44% among elderly patients and only 12.4% among younger patients at risk… and there was a "clear need" to increase uptake, particularly among vulnerable people under the age of 65, for 1999.'

In subsequent years, leading up to the epidemic, there was a 'flu awareness week' and a third of a million more flu jabs were shoved into people's arms. Nevertheless, people died and one hospital stored bodies in refrigerated trailers.

If all this sounds familiar, it's because it is! Here are some more interesting factoids:

- The General Secretary of the day, at the Royal College of Nursing, Christine Hancock, said: 'It is nurse shortages that have led to this year's crisis in the NHS. We cannot provide good patient care when we are short of some 12,000 nurses. A good pay rise would boost numbers immediately.' She warned that even a 5% pay rise would not remedy the nursing shortage.
- The NHS Confederation said a survey last week of 267 healthcare trusts [Note, we don't have that many these days] with acute beds showed that the most common reason cited for constraints in admitting patients to hospital was pressure on beds, followed by difficulty recruiting and retaining nurses and staff illness and absenteeism…
- …with bed occupancy at around 95% there is no margin at all for emergencies, and the question now being asked is, 'Do we have enough beds?'
- ... Nurses' pay is an absolutely key issue, but we don't want to see a massive hike this year. [That was because they knew they'd have to fund it internally.]
- And the Health Select Committee, recommended, 'unification of health and social services ... to end the confusion over continuing care for elderly and disabled people.'

If all this sounds familiar, it's because it is!

Here we are again. By George (Santayana), history is coming back to bite us.

The NHS is run at the behest of politicians. The NHS then runs behind them, trying to make sense of their decisions, neglect, ignorance and stupidity. All of what we are experiencing now was foreseeable, avoidable and unnecessary. We could have enough beds, enough staff, enough capacity and enough nous to sort out the NHS and social care problem … If we had enough elected representatives with enough brains.

Alas, more than enough people have died. ..because we don't.

Things we all can do

God knows where we go from here. People ask me interminably, 'What can we do about the NHS?' I was born before the NHS. My mum worked in a shop and my dad was a window cleaner. I was born in Burdett Road, in the East End of London, in a flat above a shop. Going to hospital was out of the question and my dad paid a woman who wasn't really a midwife to come and help my mother give birth (she'd lost her first baby, so today we would regard her as a woman at risk), but she just had to get on with it. She was 12 hours in labour on a hot June Sunday night, but she said it was worth every minute! So I turned up and it wasn't until a few years later that the Labour government nationalised the existing infrastructure and we had what I think was the defining moment of political history in this country – the NHS. I don't think there's any other decision our politicians have taken, apart perhaps from sending our young people to war, that's had such an impact on society and, for me, that's where it all begins and all ends.

I'll tell you another story from my hinterland. I was a couple of years old and I was very poorly. Mum didn't know what to do, so she got her mum to come round and look at me. She didn't know what to do either, so she asked around the neighbourhood, because that's what you did around the East End, but nobody knew what was wrong with me. You'll be sitting there thinking, 'Why didn't they go to the doctor?' I'll tell you why – because working people did not believe that the NHS was free. They couldn't afford it.

It was 10 o'clock at night and my dad was very worried. 'We're going to have to do something!' So he wrapped me in a blanket, picked me up and carried me 2 miles to where our GP lived. He walked up the gravel drive, knocked on the door, the light came on in the hall and the door opened. There was the doctor in his dressing gown and my dad said, 'I'm really sorry, Doctor, but I don't know what to do. My little boy is ill and we can't figure it out. My missus doesn't trust the NHS as being free and we can't pay for it, so can you help us?' And he said, 'Of course. Come in.' And he took me in. His dining room was his waiting room. He examined me and said, 'Mr Lilley, your lad needs to go to hospital.' And my dad said, 'Well, I don't know how I'm going to get there.' And the doctor said, 'That's all right. I'll take you and we'll find out if the NHS really is free.' They took me to the local hospital and I had a twisted bowel, which can be a bit dodgy when you're little and they fixed me up. I feel emotional about it, because, for me, that's the NHS. Our NHS. And we've gone from family practice to industrialising primary care – and it's bloody awful. And he was a wonderful man, you know. He had cuff links and we rolled up our sleeves. He had a waistcoat and we had jumpers. And he had a car and we had bikes. And when he took me to hospital, it was the first time my dad had been in a car.

Now I don't know how we get back to that. It's not that the good will does not exist within the medical profession and I do not believe that there is any doctor worth the title of doctor that would not do what that doctor did for my dad that night. It's just that we don't give them the time and the space to do it.

Some of you were talking earlier about 'management' and you're right: a lot of managers are useless. The trick of management is always to hire people who are better than you and give them the time and space to do great things. That's all you have to do, but we don't create the time and space for them to do great things. We fill their time up with nonsense and regulations and forms and what the hell else and that's what annoys me.

It just makes me so bloody angry and that's what keeps me going. Why do I write this damn thing every day and why do I trail around hospitals and come to places like this? 'What shall we do about it?' Well, we could burn down Westminster, but it wouldn't matter. No-one would notice. We could write to our MP, but they have a thing they call a shredder – waste of time.

I think we need to be much more curious. Curiousness. You know; when you get home in the evening and you slump on the sofa and you use the most fabulous invention known to man – the screw-top wine bottle – no corkscrew required! And you pour yourself a large one and sit back and say, 'God, I've had a great day today – I've done a great job.' Well, how do you know? How do you know you've done a great job? How do you know there isn't somebody doing just the same job in the next town, the next county, the next country, that isn't doing an even better job than you? Because you don't know. Maybe, just maybe, you really are the one that is doing the best at the particular job that you do. How do you know that you haven't got the edge that puts you half an inch in front? How do we know without sharing it? We certainly won't get better by inspecting things: we will get better by sharing the best of what we do, as long as we are curious. So I think curiousness is important.

Skilfulness is important. I don't think we address skilfulness in the way that we should. Do you remember when doctors said, nurses shouldn't take blood pressures? Do you remember when the BMA said nurses shouldn't use stethoscopes, because it would interfere with the relationship between the doctor and the patient? There is much more that we could be doing. If you say to a nurse, 'I want to talk to you about productivity, she'll kick you in the cobblers, and you will have deserved it. But what if you say to a nurse, 'I want to make your job easier. I want to make it possible for you to do what you do, because what you do is really good. How do we get more of you?' Look at simple things – non-medical prescribers. The NHS employs 1.3 million people, of whom around 300,000 are nurses. How many are non-medical prescribers? 9,000. Occupational therapists and physiotherapists. You say to the physio, 'I've got this terrible pain in my elbow' and she says, 'You've got to see the doctor and get a prescription for a painkiller, because I can't do it, because I'm only a physio and I've only got half a brain.' Not true. We are only using half a brain. Throughout the NHS there are people employed who only use half their brain because we only allow them to use half their brain. We only half train them. We don't get them to work at the outer edge of their registration. Skilfulness is important.

And the third thing is helpfulness. We just have to ask ourselves, 'Is what we're doing helpful? Is what we're paying helpful? Is our business plan helpful? Is what we're asking people to do helpful? Are our relationships helpful?'

When people say to me, 'What can we do about the NHS?' – curiousness, skilfulness and helpfulness are the three things we can all do.

A nudge is not enough

And there is a fourth thing. What are we going to do about the demand that there is now on the NHS? How do we stop people getting sick in the first place? Almost every public health initiative I have ever seen in 50 years of being an NHS watcher, has been completely and utterly useless. It is the law that changes our behaviour. Think seat belts in cars; crash helmets on motorbikes; smoking in the workplace; the Clean Air Act. What law is there about obesity? We could pass a law that said no chip shop should have a door more than 9 inches wide. We could pass a law that said every bus stop should have a set of scales – you can't get on the bus until you've weighed yourself – the

bus driver says, 'You're overweight mate: you've got to walk!' Our whole approach to public health doesn't work.

I'm going to read you something about what we do to reduce the numbers using the NHS:

'Twas a dangerous cliff, as they freely confessed,
Yet the walk near its crest was so pleasant,
But over its terrible edge there had slipped
A duke and many a peasant.
So the people said, something would have to be done,
But their projects did not at all tally.
Some said, 'Put a fence round the edge of the cliff',
Some, 'An ambulance down in the valley.'
But the cry for the ambulance carried the day,
For it spread through the neighbouring city,
A fence may be useful or not, it is true,
But each heart became full of pity
For those who had slipped o'er the dangerous cliff
And the dwellers in highways and alley
Gave pounds and gave pence, not to put up a fence,
But for an ambulance down in the valley.
'For a cliff is all right, if you're careful', they said,
'And if folk even slip and are dropping,
It isn't the slipping that hurts them so much
As the shock, down below, when they're stopping.'
So, day after day, as these mishaps occurred,
Quick forth did those rescuers sally
To pick up the victims that fell off the cliff
With their ambulance down in the valley.
Then an old sage remarked, 'It's a marvel to me
That people give far more attention
To repairing results than to stopping the cause
When they much better aim at prevention.'
'Let us stop at its source all this mischief,' he cried,
'Oh neighbours and friends, let us rally.
If the cliff we might fence, we could almost dispense
With the ambulance down in the valley.'

– 'The ambulance down in the valley'
Joseph Malins (1895)

I don't have any answers, really. All I know is, history repeats itself. If we're curious, skilful and helpful and if we consider how we stop people getting sick in the first place, then although I was born before the NHS, it may not end before I do.

Roy then gave a generous amount of time to taking questions from the floor, summarised here.

Where's the front door?

Q Some years ago, the BMA launched something they called 'The doctor-patient partnership', when they thought we might do better if doctor and patient were on more equal terms. It didn't last very long, but in terms of influencing behaviour, do you think it could contain the kernel of an idea that could grow further?

A I agree. I was on LBC last night, talking about the confusion of where do you go when you're ill? Do you go to your pharmacy? To your local health centre? Do you try and get hold of your GP? Or ring 111? Or ring 999? Where's the bloody front door of the NHS? The front door needs to be the GP. Hire a load more GPs; pay them a proper salary; get them properly organised and that is the front door to the NHS. The rest, in management terms, is just diffusion of demand. If demand is reduced somewhere, managers think it is reduced everywhere. If you ring 111, unless you've got something trivial, they're going to tell you to go to your GP or go to A&E. It's a complete waste of

time! What retailer would have five entry points to sell whatever they're doing?

There's a good report from the University of Cambridge [2] considering what is an 'inappropriate encounter'. Nobody could explain it, because if you go because of a bad back, and it turns out you've got metastatic prostate cancer, then it turns out to be quite an important backache. If you've just been doing a spot of gardening, all you need to do is use a hot water bottle and get over it. But you don't know until you get there and what's important to some people might not be important to others.

As a society, we have lost the option of what I used to do, when my mum was alive: I used to ring her up and ask her. GPs used to be the confessor; they used to be family; they were at the centre of our communities. Now, of course, you have to speak to a Care Navigator.

Making a difference?

Q How do we influence the next Labour Secretary of State for Health to do the sort of things needed to change the NHS for the better?

A Wes Streeting won't be the Secretary of State for two reasons. He's put his foot in it so many times that he's going to have too much of a legacy: he's going to have to scrape all that off his boots and he won't be able to do it. He's said some stupid things today. He's had a go at GPs; he's had a go at the NHS; he's had a go at managers; he's arrogant and we'd be better off without him. That's why they never put the Shadow into the same post in government, because they will have had to say a lot of stupid things on the way.

And secondly, I'm not sure Labour are going to win the next general election. It would take a bigger swing than Blair had in 1997 and Starmer is not Blair. Unless Labour can do something about Scotland, they need a swing of about 14% and

they won't get it. I think it's likely to be a hung parliament or a very tight majority, because the Tories are going to rein everything back; there's going to be a bonanza of spending, tax breaks and God knows what. You can see what they're doing. Jeremy Hunt, who I know personally, is as crafty as a box of foxes.

The NHS can't do it on its own

Q What you were saying about curiousness, skilfulness and helpfulness needs to be applied equally to care workers. They are key and need to be recognised through training, and remuneration and conditions of employment.

A You're absolutely right. We've just given local authorities £250 million short-term funding to buy domiciliary care packages which do not exist. Hospitals are chock-a-block with people who are medically well, but not medically fit. It requires local authorities to contract mainly with homecare, because even though we are going to put 13,000 people into care homes now, they still have to come out of those care homes and back to their own homes and many will need support to do that. So, in the end, we rely on domiciliary care companies which are usually small, locally-based businesses, doing a good job, mostly on the brink of financial collapse, without much in the way of reserves. The whole sector needs to be

strengthened.

We need to understand that the average wage of a care worker is under £10 per hour: for many it's about £9.30 per hour. Last week, Sainsbury's announced that their low paid staff would get £11 per hour. You can't compete against £11 with £9.30. Even if you love the little old ladies you're looking after, if your kids need new shoes to go to school, you've got to go and work at Sainsbury's. And, after you've worked there for 3 months you get 20% off your groceries and 12% off your homeware. Care work could be a fantastic job, but it needs consolidation, with a proper career structure, and training to do more useful things – skilfulness. There's a great hospital in Northumberland, run by a good mate of mine, Jim Mackey. He got totally hacked off with the local authority being unable to do their job, so he started a domiciliary care company as part of Northumbria Healthcare NHS Foundation Trust.

Home to roost

Q I'm a working GP. I agree about the need for a single point of access: less confusion for patients and it was predictable that NHS 111 would produce supply-induced demand. We knew Care Navigators were receptionists rebranded, but we're given money for navigators and we're pragmatists. We say, 'Give us the money and we'll call them Care Navigators or whatever you like, even if they are receptionists. How do we stop the government spending money on stupid things?

A Short of a revolution, you need to understand that politicians only have two levers in Whitehall – bungs (money) and beatings (guidance and controls). I was doing a phone-in last week and somebody said, 'The government has given the NHS all this money', but there is all the difference in the world between funding for firefighting and actually investing in the NHS. After the financial crisis we had 10 years of nearly flat-line funding, under 2%. The NHS needs 4% each year just to keep going. We didn't build enough, repair enough, get enough kit, recruit enough GPs and other staff. All of that meant that, when Covid hit, we had waiting lists of 4.5 million and were short of 40,000 nurses. Now we're coming out of the pandemic with 120,000 staff vacancies and waiting lists of 7.5 million, but the damage was done in those 10 years.

The sky is dark today with chickens coming home to roost. The knee jerk reaction of government is to throw money at it, whether it's teaching, prisons, the NHS – bungs and beatings. When people ask why the health system is so much better in France and Germany, they need to understand that it is not the system. They have just had a sustained period of better funding.

I'm going to give you two numbers to write down. Put them on your fridge. Tell your partners and your friends. In this country, per head of population, for healthcare we spend £3006 per person. Across similar countries in the EU, they spend £3663. Consistently 18% more.

You get what you pay for.

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Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

Coronavirus was never the only threat...

- The NHS is not safe. Its protection is not guaranteed.
- Funding promises are not enough. They never were.
- The public are seeing the damage being done. But who will they blame?
- You didn't take up medicine to see the NHS die.

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