DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

The NHS Can Be Saved

Page 3

APRIL – JUNE 2024

CONTENTS

If you would prefer to download your newsletter from the website (https://www.doctorsforthenhs.org.uk/newsletters) and stop receiving printed copies please let Alan Taman know.

Managing Editor – Alan Taman
healthjournos@gmail.com
Published quarterly. Contributions welcome. Next issue: July – September 2024

A View From the Chair

We all have a part to play in ensuring that there is a well-informed public discussion on the NHS and wider health policy in the run-up to the next general election.

We can each make use of our professional experience to explain how we have reached the present situation and what actions can be taken to restore our health services to a level that better meets our needs.

In November's Newsletter I drew attention to *The Rational Policy Maker's Guide to the NHS* (1) from the 99 Percent Organisation, which sets out clearly many of the arguments and debunks many of the myths about the failings of the NHS.

Over the past few months, a series of reports derived from the BMJ Commission on the Future of the NHS have been published in the *BMJ* (2) which add to the body of evidence and opinion that can be used to influence public and political debate during this period when future policies are being shaped in preparation for election campaigns.

Time to wake up

Although the NHS is the largest employer in the country, employing 1.7 million people, and accounts for public spending equivalent to 9.3% of GDP, many people have only transient contact with the NHS, possibly experiencing frustration with availability of GP appointments, but generally confident that the service will be there for them should the need arise. Certainly, the health of the UK had been improving steadily from the 1930s due to a combination of improvements in public health – nutrition, housing, sanitation, vaccination and safer workplaces – together with better access to medical treatment through the National Health Service. However, there are many signs that those improvements are being undermined both by a deterioration of performance in the NHS, but also greater disparity in the living conditions between the more deprived and the more affluent members of society – the social determinants of health. These findings should act as warning signals that all is not well and that an urgent response is needed from our leaders to reverse the trends that are becoming increasingly apparent.

Despite us being constantly told that we are all living longer, figures from the Office for National Statistics for 2024 have confirmed that life expectancy has not improved in the UK since 2020-12, for either males or females (3). In addition, *The Marmot Review 10 Years On* showed that the proportion of life spent in ill-health and disability has increased for both sexes and revealed the familiar pattern of greatest detriment being experienced by those living in situations of deprivation (4). Further analysis has confirmed that between 2011 and 2019, more than a million people died earlier than they would have done if they had lived within the 10% least deprived areas of England (5).

Infant mortality had been reducing in the UK for more than 50 years, but has not improved in the UK for the last 20 years and the UK remains near the bottom of the table of OECD countries by this measure (6). Most of this is due to increasing infant deaths in the poorest families, with mortality continuing to reduce in wealthier families.

The model isn't broken

The Commission considered the question as to whether the founding principles of the NHS are still appropriate today – a comprehensive service, universally available, based on clinical need, free at the point of need, and funded through collective taxation – principles that DFNHS has always espoused. Members will welcome the conclusion

of the Commission that these principles are as relevant now as they were in 1946.

Critics of the NHS say that, if it is so good, why have other countries not adopted the same model, but the Commission points out that the NHS is not unique and that most western European systems are based on comprehensiveness and universality.

They assert that there is a need for the next government to acknowledge the perilous position of the NHS, recommit to the NHS and its founding principles and engage all parts of society in a renewed vision and plan for health, care and wellbeing, and win public support for the measures required to carry that plan through over a number of years. There is a need for all areas of government to contribute through policy developments in their specific policy areas, such as housing, environment, employment, benefits, and for wide involvement of the general population – health is everybody's business.

Repeated attempts have been made to question the way in which health services are funded, particularly by those convinced that tax is theft. The main contention is between a tax-based funding model or a social health insurance scheme. Some countries have changed their model – Denmark, Greece, Iceland, Italy, Norway, Portugal, Spain and Sweden all changed from a social insurance to a tax-based model between the 1960s and 1980s. In contrast, the Czech Republic, Hungary, Poland and the Slovak Republic changed from a tax-based system to social insurance. The conclusion was that there is no convincing evidence that making a switch to the funding model of the NHS towards a social insurance scheme would justify the upheaval and cost of making that transition. Our tax-based system also benefits from economy of scale, is cheap to administer and benefits from creating a sense of public commitment and social solidarity.

We need stability

A key problem is the vulnerability of the NHS to short-term political expediency and budget instability. The Commission recommends the establishment of an Office for NHS Policy and Budgetary Responsibility (OPBR), along the lines of the Office for Budget Responsibility which was set up in 2010. The OPBR would provide an independent and expert assessment of NHS plans and policies. This would produce an annual report on the performance of the NHS, including population health outcomes, access and waiting lists, an analysis of patient and public satisfaction and an analysis of expenditure. Every 5 years, before a general election, they would publish a report on the future of healthcare for the subsequent 10 years, covering expected demographic changes, technological advantages and opportunities for increased productivity. It would also provide a very long term forecast (50 years) of spending pressures based on known drivers of such pressures.

> "There is also the need for an immediate cash injection to deal with the current critical state of the NHS, to include funding for projects delayed over 10 years ."

Governments should be required to respond to the report within 6 months of taking office, making use of consultation with the public and the professions and explaining their priorities. This would result in a five-year strategic plan with a detailed five-year funding settlement, and a provisional settlement over the next 5-10 years. This plan would be subject to scrutiny by the OPBR.

There is also the need for an immediate cash injection to deal with the current critical state of the NHS, to include capital funding for projects

that have been delayed over the past 10 years, including the backlog of maintenance on the NHS estate estimated at £10.2bn in England in 2022. The suggestion is an immediate real increase of 4.5% (£8.5bn) in the first year of the next parliament and in each of the next 4 years, to return the budget to the level that it would have been, if the historic average funding increases had been maintained from 2010 onwards.

It's a people business

The success or failure of the NHS rests with its workforce, but workforce strategy has been neglected for too long under the short-termism of recent health policies. The Commission established that the NHS does not have sufficient staff to achieve its goals, with fewer doctors, nurses and managers than peer countries – increased absolute numbers of staff in particular disciplines does not mean that there are enough to cope with the increase that has occurred in total population, particularly the total increase in older people.

> "Workforce strategy has been neglected for too long under the short-termism of recent health policies... the NHS does not have sufficient staff to achieve its goals."

The go-to solutions to unfilled posts, of resorting to locum agencies (unaffordable, inefficient and risky) or overseas recruitment (ethically dubious or facing stiff competition from other developed nations with similar staff shortages), are becoming less viable options. We need to develop a self-sustaining workforce model.

The introduction of staff involved in direct patient care in new roles receives considerable attention, particularly the proliferation of nurses, paramedics, pharmacists, physician associates and social prescribers in primary care. A contrast is drawn between the generally successful incorporation of advanced nurse practitioners and paramedics into practice teams, with the expansion of physician associates, as described in John Puntis's article in this Newsletter (see page 13). The call is made for great care to be taken in the planning, monitoring and evaluation of new disciplines, to define their scope of practice and the regulatory framework within which they are to work.

The importance of improving working conditions in order to retain staff and maximise their contribution to the NHS is recognised. Dissatisfaction with the level of pay is a factor for many staff, but not the only factor. Acknowledgment of the cost and disruption of working antisocial hours through support with transport and childcare could make a significant difference to staff morale.

A job that is hard enough at the best of times may be made much more difficult by lack of basic facilities in the workplace – such as lockers, toilets, fridges, access to food and drinks, and workstations – which contributes to a sense of being undervalued. At the start of a new job or placement, the process of getting set up with IT accounts, payroll administration, duty rotas and identity badges can be a drawn-out process, adding to the stress of a new workplace and new colleagues. And the frustrations do not end there – poorly designed and configured IT systems can continually sap the energy and take up valuable time that should be spent in caring for patients.

There are persistent problems with the culture in too many workplaces within the NHS, with bullying, harassment and discrimination at worryingly high levels, contributing to patient safety problems if staff feel unable to speak out about issues that they have identified for fear of reprisal. The loss of confidence in the transparency, consistency and fairness of professional regulatory

practice, which often seems disproportionately applied to professionals from ethnic minorities, is reflected in the discussion on scrutiny panels elsewhere in this Newsletter (see page 9). In part, it may be due to the wide variation in quality and availability of human resource expertise within NHS organisations, as well as a concentration on reputational protection of the employing organisation.

Tough on disease: tough on the causes of disease

One of the most powerful sections of the Commission's report concentrates on action required to tackle the social determinants of health.

Despite the rhetoric on the importance of preventing ill health, in order to reduce the demands on NHS and other services later in life, this has not been accompanied by investment in public health services, where there has been a reduction in per capita spending of 27% in England and Northern Ireland since 2015-16.

The Commission reports include evidence of the intersecting factors contributing to these inequalities, including the region of the country, race, income, housing and education, and point to the damaging effect on the health of the wider population from poverty, particularly the level at which Universal Credit is set, which is insufficient to maintain a healthy life.

The decline in physical and mental health of young children, outlined in a recent report from the Academy of Medical Sciences, should cause serious concerns because the foundation for so much chronic illness in later life is laid down at the start of life (7) and the future prosperity of this country depends on our investment in the next generation.

Importantly the Commission makes clear recommendations for action by an incoming government:

- Implement policies to tackle poverty, so that individuals and families can lead healthy lives, including the level at which national minimum and national living wages are set, the level of Universal Credit and a more equitable distribution of corporate profits to reduce in-work poverty.
- Investment in housing compatible with good health, including affordable, good quality, sustainable housing and retrofit of the existing housing stock.
- Giving every child the best start in life, through policies to reduce childhood poverty, targeting additional spending towards supporting early years in more deprived areas and reversing the decline in mental and physical health of children and young people.

It interestingly highlights actions that can be taken by the NHS, as the largest employer in the country, to improve the working conditions of its staff and the conditions of their families, as well as the role of NHS organisations in supporting the communities in which they are based and local economies from which they buy goods and services. The recommendations also suggest ways in which each individual working within the NHS can act to reduce the adverse impacts of social determinants of health on the patients and colleagues they encounter.

Don't let the moment pass

This is just a brief résumé of an authoritative and concise report with sufficient clear recommendations that shows there is a way out of the mess that we have created of our nation's health. I would encourage you to share it as widely as possible, amongst colleagues, political candidates and the general public and to use it as a catalyst for a radical rethink of our approach to the NHS and public health. We don't know whether the opportunity will arise again.

References

1. 99% (2023) *The Rational Policy Maker's Guide to the NHS* [Available at: https://tinyurl.com/2pj8zmjz]
2. *BMJ* (2024) The BMJ Commission on the Future of the NHS
[Available at: https://tinyurl.com/s78nay8h]
3. Office for National Statistics (2024) National life tables – life expectancy in the UK: 2020 to 2022
[Available at: https://tinyurl.com/32raxvrk]
4. Marmot, M. (2020) *Health Equity in England: The Marmot Review 10 Years On*
[Available at: https://tinyurl.com/2s4fmkky]
5. Institute of Health Equity (2024) *Health Inequalities, Lives Cut Short*
[Available at: https://tinyurl.com/bdcm6h9b]
6. RCPCH (2024) Infant Mortality
[Available at: https://tinyurl.com/49yd5pvz]

7. The Academy of Medical Sciences (2024) Prioritising Early Childhood to Promote the Nation's Health, Wellbeing and Prosperity
[Available at: https://tinyurl.com/38etmbe6]

Colin Hutchinson
Chair
colinh759@gmail.com

Working Groups: Can You Help?

As the UK heads into what will be one of the most important general elections for the NHS, if not the most important, health campaigns througout the UK are starting to marshal their thoughts and resources on how best to meet the challenge of getting their messages across to the electorate (mindful of the need to observe electoral law and remain non-partisan in advocating any views on voting).

DFNHS has always stood for promoting non-partisan views, and we will speak to anyone about our objectives and the need to uphold the founding principles of the NHS, whoever people might choose to vote for.

There are of course many campaigns, but DFNHS has a unique stance in remaining the only national organisation where members are doctors and which campaigns to uphold NHS principles as its overriding objective. That gives us a voice which 'punches well above our weight'. But it will be getting very noisy, leading up to the general election, whenever it is called. How can we best marshal our resources, to collaborate with others and also promote our messages?

One of our core strengths lies in our expertise: we are doctors. One way of channeling that is to set up and run working groups on specialist topics. There is nothing new in this: but one silver lining from the pandemic is the now almost universal use of remote video conferencing for meetings, and that gets around the difficulty members may have faced in the past in meeting up. It is now practical to run a working group with people from all over the country perfectly well, in a way which e mail or phone calls alone could not do (though these will still be used).

To that end, we would like to hear from you about any suggestions you might have for a Working Group. This need not be a unique focus for DFNHS: the idea would be to collaborate with other groups who might also be working on similar fields as appropriate. But if you could consider joining a discussion group to see what might be done, and if a Working Group could then be set up, please let us know (via Alan Taman at healthjournos@gmail.com; or via doctors4thenhs@gmail.com).

One obvious topic would be physician associates and other 'new' groups. Several EC members have already expressed an interest in setting up a group to look at this.

Other suggestions include a group looking at data and Big Tech; on ending the social care disgrace; mental health; general practice; and bottlenecks for postgrad training. But all ideas are welcome.

DFNHS has a lot to offer, with our collective expertise. If you can help by contributing to a Working Group, please let us know. Alan will offer whatever support may be needed to set up and run any groups. These will then report back to EC, but how each group explores its topic would be up to the members of each working group.

Scrutiny Panels: A Step Nearer?

DFNHS has joined with 15 other organisations in presenting evidence to Parliament's Health and Social Care Committee (HSCC) Inquiry into NHS leadership, performance and patient safety, in a bid to improve the way disciplinary procedures are carried out in hospitals. The Inquiry accepted the evidence to consider.

Currently, 'disciplinaries' are far too often carried out in a way that resembles a 'kangaroo court' by Trust senior managers, with little to no regard for the Maintaining High Professional Standards in the Modern NHS (MHPS) (1) framework for the handling of concerns about doctors and dentists in the NHS in England, leading to widespread unfairness and perpetuating what is already a deepening blame culture within the NHS.

DFNHS members Arun Baksi, Helen Fernandes and Malila Noone have worked, with others, on a proposal to replace the current disciplinary system with one that relies on elected Scrutiny Panels for each Trust, which would gauge concerns about doctors initially but could be extended to cover other health professionals. Their work contributed greatly to the evidence submitted to the HSCC. You can view the full document on the DFNHS website (https://tinyurl.com/muy8zs48).

The summary of the evidence says:

'Recognising that unfair proceedings have wide implications, MHPS was introduced in 2005 to tackle the blame and suspension culture. NHS Employers collaborating with the BMA wanted a framework that would guide disciplinary proceedings, minimising suspension, and the involvement of lawyers. Regrettably, these objectives have not materialised as intended. Sir Robert Francis in his 'Freedom to Speak Up' (2) review criticised the use of disciplinary procedures by NHS Trusts saying, 'employers often felt challenged in how to separate safety concerns from disciplinary issues'. Guidance on the appropriateness of disciplinary action in the form of 'A Just Culture Guide', has not improved practice (3). An imbalance in the workforce in relation to bias in disciplinary action has long been recognised and ambitions to correct this set out (4,5). Recent events in the Countess of Chester Hospital and other high-profile cases highlight the ongoing failure of those in management positions in our NHS Trusts to be relied on to act appropriately when patient safety concerns are raised by staff members.

'Data is available that shows that the cost to the NHS of pursuing these proceedings is unknown, unaudited and unregulated. As a result, no learning or best practice models exist. Investigation is not only hugely stressful for the individual member of staff but impacts on their immediate colleagues and members of the wider institution. These negative effects would further impinge on patient care and safety. Current industrial action by doctors is seeking better working conditions, a better culture, not just asking for more pay but for better management. NHS staff want to feel safe in their workplace and have confidence in management structures, when reporting concerns and disciplinary proceedings.

'It is of great concern that despite many catastrophes over the past thirty years, the changes introduced to address them, including the Kark Review, have been largely non-statutory. This has resulted in avoidable harm

to the public and to staff raising concerns. Each acknowledgement is followed by a statement that lessons have been learnt!

'Without meaningful change, the press will continue to headline with cases like those sad examples witnessed over recent years in Chester and Birmingham and many more. We believe that the only way to address behaviour is the introduction of a LAW to drive the changes that will support staff expressing their concerns, and faith in their hospital management. The relevance of a law in changing behaviour and culture is shown by its effects on wearing seat belts and smoking amongst many others.

'Our proposal seeks to establish independent Scrutiny Panels with powers set out by statute in each hospital, from which management would have to seek permission before undertaking any investigatory or disciplinary action against staff. The panel could also function as the local guardians for Freedom To Speak Up for each hospital, synergistic with the Protection for Whistleblowers Bill currently making its way through Parliament that calls for the introduction of an independent Office of the Whistleblower. The establishment of scrutiny panels would make an immediate and palpable improvement of the current corrosive culture of fear confronting staff across all disciplines in Hospitals.

'It should go without saying that all disciplinary action should follow the principles of natural justice; those are "Adequate notice, a fair hearing, and the absence of bias".'

The document then outlines the work carried out to establish the case for change (which has been reported before in this newsletter, see *DFNHS Newsletter,* January 2023), then sets out the formal proposal for Scrutiny Panels:

'We propose that the government establish an Independent and elected Scrutiny Panel with full statutory powers in each hospital. Management would have to seek permission from this Panel before embarking on any formal investigatory process following informal enquiries in all cases.

'This panel would also function as the Local Guardian for Freedom To Speak Up (FTSU) thereby providing protection to staff against any recrimination.

'The changes proposed are designed to identify and stop unfair and malicious proceedings from the outset. This process would result in an overall reduction of formal investigations, prevent the significant negative effects on doctors and their families and significantly reduce costs and wasted time. We believe that the introduction of the Independent Scrutiny Panel would improve trust in processes, remove bias and change culture in a positive way.

The details of the Scrutiny Panels. – including how elections should take place – are then described further.

In conclusion the document states:

'Changes made to the investigation and disciplinary process of doctors have failed to prevent increasing instances of unfair, biased, and malicious proceedings. Natural justice has not prevailed. The proposals made in this paper serve to rebalance the current situation by establishing an independent and elected

statutory Scrutiny Panel in each Trust.

'Currently there is no meaningful process in place to monitor and audit disciplinary proceedings and their outcomes. There is no record or audit of monetary costs.

'While doctors have been penalised when found to be guilty Trusts have rarely been subjected to any form of scrutiny or disciplinary action when their actions may have been incorrect or misplaced. This issue requires further consideration.

'It is envisaged that, should the principle in the proposals be adopted, the system could be rolled out to primary care, the nursing profession, allied health professionals and other members of staff. It is also our expectation that these proposals would be adopted by all devolved nations.

'While we agree that there is room to improve the regulation of medical managers, following the absence of accountability of those overseeing concerns in the Letby case we believe that a knee jerk response could mask the underlying and complex cultural issues and could be just another retrospective move that would do nothing to help control the initial stages of investigating staff. Simply put, regulations of this type come into action too late – shutting the stable door after the horse has bolted.

'In summarising our proposals, emphasising that the first responsibility of every doctor is to do no harm, the overarching objective of the Independent Scrutiny Panel is to protect the public interest which includes ensuring that everyone involved in the Trust act in and put the public interest first.

'We welcome and support plans for the introduction of the Office of the Whistleblower currently going through Parliament (6).'

The Inquiry will now consider all of the evidece accepted before submitting its full report to Parliament. How this will affect legislation is impossile to gauge with certainty (especially in the current political climate!), but DFNHS has always adopted an approach of informing any agency of its concerns and the evidence underpinning them, in trying to protect the NHS. This is an important step in ensuring decision makers have reliable evidence submitted to them.

References

1. MHPS (2005) *Maintaining high professional standards in the modern NHS*
[Available at: https://tinyurl.com/bdzk8msk]
2. Francis, R. (2015) *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS* (The Francis Report)
[Available at: https://tinyurl.com/266vk7vp]
3. NHS England (2024) *A Just Culture Guide*
[Available at: https://tinyurl.com/3bsjhfws]
4. NHS England and NHS Improvement (2024) *A Fair Experience For All: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce*
[Available at: https://tinyurl.com/msre93cc]
5. Atewologan, D., Kline, R. and Ochieng, M. (2019) *Fair to Refer? Reducing disproportionality in fitness to practice concerns reported to the GMC*
[Available at: https://tinyurl.com/4sh7wdxh]
6. House of Lords Library (2021) Office of the Whistleblower Bill
[Available at: https://tinyurl.com/ye3cjtd7]

RCP Eric Watts Award: Winner Announced

The Eric Watts Award for excellence in patient care and patient engagement (see *DFNHS Newsletter*, October 2023) was conceived as a way of giving recognition and encouragement to ideas with potential that deserve recognition. The criteria for the award requires an evaluation that the ideas had resulted in clear improvement.

The award was announced last year, and closed to entries in January 2024. A total of 26 entries were received, mostly projects initiated by healthcare professionals. Results were announced at the end of April.

The winner was The Lincolnshire Living with Cancer (LWC) Programme, established to improve the challenge of providing cancer care throughout their locality. The project captured the spirit of the award by stating: 'We knew what we had to achieve; however, we didn't know what the challenges were for Lincolnshire people following a cancer diagnosis, or how to approach this enormous task in our rural and coastal county. There is a temptation for professionals to see ourselves as the experts in our field, know what the problems are….' The Programme has since been published (1).

Runners-up included two other cancer-related pieces, indicating evolution within the oncology community that cancer patients are better seen as partners than passive recipients.

One, from the Marsden Hospital, described their approach to older patients with cancer, for whom standard therapies may be too powerful. While several examples of geriatric oncology programmes are available worldwide, only a few specific care models are available in the UK. With support from the Cancer Alliance RM Partners and ongoing input from patients and caregivers at the hospital, the team developed the Senior Adult Oncology Programme (SAOP), the first multidisciplinary team-led, consultative, geriatric oncology service to be implemented in a tertiary cancer centre in the UK. This service offers CGA to patients aged 70 years and above being considered for systemic anticancer therapy (SACT) selected based on a validated geriatric screening tool (SAOP3).

Another, from Guys, set to improve patients well-being through a supported exercise programme. Guys Cancer physiotherapy team partnered with South East London Cancer Alliance (SELCA) to lead on a funded project to encourage quality conversations about physical activity throughout the cancer pathway.

Amongst the other entries a particularly exciting one dealt with the approach in Cambridge to children and young adults with inflammatory bowel disease. To combat the dangers of the illness preventing normal development to adulthood, a combined approach by parents, patients and professionals led to a snowball effect of learning programmes and blossoming of developmental workshops.

There were other initiatives to show the caring approach going far beyond the standard approach.

The judges were unanimous in praising all of the entrants for showing their awareness of patients' needs and their determination to address them.

Reference

1. McPeake, K., et al. (2023) 'Developing a "Living with Cancer" programme in a rural and coastal setting: Experiences of collaborative and innovative co-production across an Integrated Health System' *Journal of Cancer Policy* 38, 100452

Medical Associate Professionals and the Implications for Quality of Patient Care: An Overview

John Puntis on an increasingly alarming threat to medicine

Physician Associates (PAs) have been much discussed of late (1, and see the last issue of this newsletter).

Reasons for this include a plan for a huge increase in numbers, public confusion about their professional status and competencies, questions about professional regulation, and a push-back by doctors against their Royal Colleges, specialty organisations and employers for not reacting to concerns over both patient safety and effects on doctor training. Campaigners' main worry is that PAs are simply 'doctors on the cheap' and present significant risks to patients while undermining commitments to increase numbers of medical staff. A report by the KONP General Practice Working Group (2) highlights some of these issues.

What are Medical Associate Professionals?

PAs are the main group within the category of 'Medical Associate Professionals' (MAPs). This also includes Anaesthesia Associates (AAs) and Surgical Care Practitioners (SCPs). All are currently working in the NHS in a variety of roles (3) across primary and secondary care.

By 2036/37 the government in England plans to increase the number of PAs from approximately 3,250 to 10,000 (an increase of over 300%), and AAs from approximately 180 to 2,000 as part of its NHS Long Term Workforce Plan (4). MAPs complete only a 2-year postgraduate course (1,600 hours of clinical experience and teaching (5)) but are being employed in the NHS in roles previously reserved for doctors, taking on increasingly complex tasks including the assessment and management of patients presenting with new and undiagnosed problems ('undifferentiated patients'). In a recent survey by the British Medical Association (BMA), a large majority of doctors expressed concerns (6) that PAs and AAs were 'sometimes' or 'always' a risk to patient safety. The BMA has called for a halt in recruitment (7) to these roles while their regulation and scope of practice are reconsidered.

What are PAs, and what are they taught during their 2-year course?

PAs were first introduced to the NHS in 2003. The Faculty of Physician Associates (FPA; hosted by the Royal College of Physicians (8)) states that:

'PAs are healthcare professionals with a generalist medical education, who work alongside doctors as an integral part of the multidisciplinary team. PAs work under the supervision of a fully trained and experienced doctor….They are complementary to GPs rather than a substitute ... and in no way a replacement for any other member of the general practice team…. By employing a PA, it does not mitigate the need to address the shortage of GPs or reduce the need for other practice staff'.

The FPA states that PAs work within a defined scope of practice and limits of competence, and:

- take medical histories from patients
- carry out physical examinations
- see patients with undifferentiated diagnoses
- see patients with long-term chronic conditions
- formulate differential diagnoses and management plans
- perform diagnostic and therapeutic

procedures
- develop and deliver appropriate treatment and management plans
- request and interpret diagnostic studies
- provide health promotion and disease prevention advice for patients.

Currently, PAs are not able to prescribe or request ionising radiation (e.g. x-ray or CT scans).

This reflects the description by universities of their postgraduate degree courses (see for example Leeds University website (9)). These are managed in accordance with the Competence and Curriculum Framework developed by the Department of Health and Social Care (DHSC), the Royal College of Physicians (RCP) and the Royal College of General Practitioners. Once they have completed a PA degree programme, all candidates must pass the PA National Examination, which is delivered by the RCP Assessment Unit.

Is training adequate in preparing for these roles?

Seeing undifferentiated patients is among a number of roles seen as controversial. In 2020, the NHSE contract specification for GP Primary Care Network (10), paragraph B6.2, made it clear that a PA must be given responsibility for providing first point of contact care for patients presenting with undifferentiated problems 'by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient'. However, in the amended GP contract for 2024/5 (11) it states: 17. Supporting guidance will also be issued to clarify that non-GP doctors (sic) should not see undifferentiated patients, and that they continue to be required to operate within their sphere of competence'. While 'non-GP doctors' might possibly be a reference to SAS doctors (12) (which the RCGP is also keen are not seen as a substitute for GPs), if this is the case, surely it would also apply to lesser trained PAs?

Seeing 'undifferentiated patients' is not mentioned in the Competence and Curriculum Framework, which does say, however, 'it is expected that over time the supervisory relationship will mature and whilst the doctor will remain in overall control of the clinical management of patients, the need for directive supervision of the Physician Assistant will diminish'. The BMA has recommended (13) that as well as not seeing undifferentiated patients, PAs should not be receiving any specialty referrals or be in roles requiring them to give specialty advice. They should not make unsupervised treatment decisions or management plans. Some GPs have questioned the usefulness of PAs (14) in general practice altogether, given the level of supervision required, and have highlighted patient safety concerns. The National Institute for Health and Care Excellence (15) (NICE) says that the clinical and cost-effectiveness of providing PAs is unknown and therefore requires research.

In a letter from NHS England (16) (NHSE) to the RCP, National Medical Director Sir Steve Powis clarified its position:

'PAs are trained to examine, diagnose and treat patients under the supervision of doctors…PAs are not doctors, and cannot and must not replace doctors…they are trained to work collaboratively with other health professionals as supplementary members of a multidisciplinary team. PAs must always work within a defined scope of competence; they are not independent medical practitioners and

must be supervised appropriately by doctors'.

NHSE also emphasises that patients must always be told (17) they are seeing a PA and not a doctor.

Representing all the colleges, the Academy of Medical Royal Colleges (AOMRC) produced a consensus statement (18) on PAs, also stating that: 'The Academy is clear that PAs are not doctors and cannot and should not be used as a substitute for doctors' and that PAs should be deployed only where there is a defined role and workforce need for them within a wider team. In addition, training opportunities for junior doctors need to be prioritised over those of PAs and protected. The AOMRC also emphasised the importance of supervision and suggested that each specialty should develop its own framework for what PAs could do.

The issue of professional regulation

The FPA was established by the RCP in 2015 to give PAs a professional home, set standards and oversee the PA managed voluntary register, while lobbying government over introducing statutory regulation for PA. One of the reasons given for establishing the FPA (and an ambition that would appear as yet unfulfilled) was 'to provide clarity to the public (19) on the different scope of practice of a doctor and a PA'. Until 2013 PAs were known as Physician 'Assistants' but government supported the change to 'Associate' as the DHSC felt the term 'Assistant' would reinforce an impression that lowly assistants (not doing complex work?), would not need to be regulated and this would thereby hold the profession back.

MAPs currently only have access to voluntary professional registration (20). Using secondary legislation, the government pushed for the General Medical Council (GMC) to become the regulatory body for MAPs. The GMC (21) is the independent regulator of doctors in the UK, formed in 1858 with a focus on supporting good and safe patient care. The BMA argued that the GMC taking on MAPs would unhelpfully blur the distinction between doctors and non-medically qualified professionals, and set out three demands (22):

- PAs and AAs should not be regulated under the GMC, but by the Health and Care Professions Council (HCPC).
- 'Physician Associates/Anaesthesia Associates' should be known as 'Physician Assistants/Anaesthesia Assistants' to provide clarity for patients.
- there should be a moratorium on employment of PAs/AAs until there is clarity and material assurances about their role and scope of practice.

> "Theresa Coffey ... waited 9 hours in one hospital ... went to a different hospital ... and was seen more quickly. She attributed this to the hospital having a PA."

The HCPC currently regulates 15 different groups (23) including paramedics and operating department practitioners and physiotherapists. This, rather than the GMC, would appear to be the appropriate regulatory body for MAPs. The debate on regulation (Draft Anaesthesia Associates and Physician Associates Order – AAPAO) took place in a parliamentary committee session that lacked depth for such an important issue (24). For example, former Health Secretary Thérèse Coffey remarked (24) that after she had waited 9 hours in one hospital, she went to a different hospital the next day and was seen more quickly. She attributed this to the hospital having a PA. On this basis, she argued that employing PAs was the best way to ensure patient care and safety.

In a radio interview on PAs before the parliamentary committee sat, Conservative peer Lord Bethell showed his depth of understanding of the issues while endearing himself to GPs (25) by stating that: 'GPs don't face huge amounts of complexity. Most interactions are incredibly straightforward. Certainly, my own experience over the last 20 years of going to my GP, it really hasn't required 10 years of training to deal with my small problems'. Clearly an implication that, in Lord Bethell's opinion at least, PAs could easily take on work currently being performed by GPs in assessing patients presenting with new problems.

In fact, as KONP has pointed out (26),people often consult with very complex stories, and their symptoms have a wide number of possible causes – some serious, some not. It takes 10 years to train a GP, then learning continues throughout working life. GPs are expert medical generalists who can diagnose, treat, prioritise and manage multiple and complicated conditions. Their particular strength is using their communication skills and clinical knowledge to make sense of presentations which do not fall into any algorithm. This last point is pertinent not least because some have suggested that PAs are part of the drive towards 'algorithimic medicine' (27) when the patient journey becomes automated.

Then Conservative MP and doctor, Dan Poulter*, gave a more sensible perspective to parliament (28):

> **'When the physician associate role was introduced, it was clearly seen as part of the solution to a shortage of doctors .... By freeing up doctors from administrative tasks and minor clinical roles, it allowed them to see more complex patients….Unfortunately, physician associates and anaesthesia assistants have been employed in the NHS in roles that stretch far beyond that original remit, and ... they appear to be working well beyond their competence. That has raised serious patient safety concerns'.**

However, the AAPAO was approved by the House of Lords, meaning that in one year from now, the GMC will become the regulatory body for MAPs.

Push-back against expansion of MAPs by rank and file doctors

As shown in the BMA survey, many doctors are concerned that PAs represent a threat to patient safety. A reflection of this concern has been that members of both the Royal College of Anaesthetists and of the RCP have forced their college executives to call an extraordinary general meeting (EGM) in order to explore the issues. At the meeting of Anaesthetists, 89% of college members (29) voted in favour of a pause in the recruitment of anaesthesia associates until a survey of members and a consultation have been completed and the impact on doctors in training had been assessed and reviewed.

Five motions were put to the EGM of the RCP including a reiteration that PAs are not doctors; a reminder that only doctors were able to authorise prescriptions and some types of investigations (30); a call for evidence around safety, effectiveness, costs and clinical outcomes for PAs; the need for more information regarding the impact of PAs on doctor

Dan Poulter has since resigned from the Conservative party and joined the Labour back-benches.

training; a call that the pace and scale of the roll-out of PAs should be limited until the medicolegal issues of regulation, standards and scope of practice were addressed. This final motion was not endorsed pre-vote by the leadership on the grounds that it was not within the power of the RCP to deliver, yet together with the others motions it was still passed by a large majority, highlighting the split between leaders and grass roots. The meeting was followed by huge recriminations (31) after it became clear that data from a college survey had been misrepresented to suggest more support for PAs than was actually the case. This resulted in much negative publicity (32) and a spate of resignations (33) from various college posts together with accusations that the leadership was 'in bed with the government' (34).

"In one London practice ... PAs were effectively working as GPs and without supervision."

Are doctors right to worry they are being replaced by MAPs?

The GMC has asked NHS England (NHSE) (35) to address the perception that there is a plan to replace doctors with PAs, stating that: 'We believe governments should also consider what they can say about future training numbers to make it clear that their workforce plans envisage significant growth in doctor numbers, as well as amongst PAs and AAs'. In December 2023, there were 8,758 medical vacancies in the NHS (36) and England would need an additional 50,000 doctors to bring it into line with similar European countries. NHS England points to its commitment in the workforce plan to double the number of medical school places over the next decade, saying this will ensure an extra 60-74,000 doctors in addition to a total of 10,000 PAs in the NHS by 2036/37. The AOMRC repeats this reassurance (37), implying that with rising demand there is more than enough work to be done by both doctors and PAs.

But just how reassured should doctors be? There has already been back-pedalling on the increase in numbers of new medical student places (38) (just 350 for 2025/6) and no new capital funding for medical schools that want to take on more students. In addition, junior doctors already see bottlenecks in training. For example, in 2021, 700 anaesthetic trainees (39) were unable to continue their progress despite 680 unfilled anaesthetic consultant posts. The government has done little to improve retention of doctors, with many threatening to leave the NHS because of poor pay and working conditions, and only 56% of those entering core training remaining at work in the NHS (40) 8 years later.

The *Panorama* programme on Centene (41) showed in one London general practice that PAs were effectively working as GPs and without supervision; and perceived lack of supervision was flagged up among major concerns identified in the BMA membership survey (42). A general practice in Surrey (43) has recently made three of its GPs redundant claiming 'new ways of working' including the use of non-medical staff, while other (44) qualified GPs report difficulty (45) finding a job. Richard Meddings, chair of NHSE but a banker by trade, argues that the medical staffing crisis could be solved not by improving retention and training more staff but by slashing the time it takes to train a doctor (46), implying (like Bethel) that doctors are currently overtrained.

The National Audit Office (47) has recently examined the modelling used by NHSE in its long-term workforce planning assumptions. There is a gap between estimated demand for GPs and number of GPs coming through. NHSE anticipates that this gap will be filled by moving work from GPs who are fully qualified to those in training (!), and to specialist and associate specialists (SAS) doctors in primary care. This seems a plan unlikely to bear fruit, and given the increasing numbers of PAs who, unlike doctors, can be employed through

the Additional Roles Reimbursement Scheme (48), it would appear more plausible that PAs will be called upon to close this gap.

How to ensure that MAPs do not replace doctors

The BMA agrees that MAPs can play an important part in NHS teams, and that doctors will continue to value, respect and support the staff they work with. Because of concerns that, post-regulation, the GMC plans to leave it to employers and the Royal Colleges to set safe parameters on scope of practice for MAPs, the BMA has produced guidance with the aim of protecting patients (49) and safeguarding medical training for the doctors of the future.

Key concepts that are covered include:

- MAPs follow, and do not give, medical directives; they act upon the medical decisions of a doctor and do not make independent treatment decisions.
- MAPs must not see undifferentiated patients (i.e. patients presenting to a GP or hospital with a new problem).
- National standards for supervision of MAPs must be set and adhered to, including that supervision is voluntary and must be consented to by consultants and GPs.

Included in the document are tables using a traffic light system outlining work that MAPs are expected to do, what they may do under the direct supervision of a doctor, and what they must not do.

We should spare more than a thought for the 3,250 MAPs currently working in the NHS as valued team members, and through no fault of their own caught in the middle of arguments about their future. MAPs currently in post should be supported, supervised and not forced to work outside their competence. A worried

representative body for PAs (United Medical Associate Professionals – UMAP) (50) has warned GP practices implementing the BMA's scope of practice of potential legal consequences arguing that it is 'inappropriate' for the doctors' union to 'unilaterally redefine and attempt to impose a scope of practice on another profession', and highlighted a lack of 'stakeholder engagement or peer review'. In response, the BMA pointed out its scope of practice document was 'designed to assist the doctors whose job it is to supervise these roles' and was written by doctors 'in the absence of such a guide on a national scale'.

Conclusions

After the RCP EGM debacle some commentators have raised fundamental questions (51) about PAs they say require answers. What special skills is it that PAs bring to the multi-disciplinary team (this is sometimes very clear, for example, for a dietitian) and what is their scope of practice to be? If they are 'medical skills' as such, what then is unique about the profession of medicine and what has been excluded from a 5-year course in reducing it to a 2 year one for MAPs?

Given common agreement across royal colleges, the DHSC, NHSE and the BMA that MAPs are not substitutes for doctors, must work within a defined scope of competence and under doctors' supervision, the BMA framework should

be welcomed by all of the above, with its aim of making sure this distinction works in practice and in the interests of everyone – patients, MAPs and doctors. However, the change of name from 'assistant' to 'associate', and the insistence that regulation should be by the GMC and not the more obvious HCPC, suggest the government wishes to see a blurring of boundaries between MAPs and doctors as a strategy for substituting a cheaper alternative for the latter. The long-term workforce plan looks unlikely to deliver the numbers of doctors we need and the failure to address doctor retention through improved pay and work conditions also suggests that the reassurances from NHSE and the AOMRC must be taken with a large pinch of salt.

It is instructive to look at what has happened in the United States (52) where PAs (called Physician Assistants) are permitted to work without medical supervision and are now growing in number at a much faster rate than doctors. This has been driven by an increase in demand for health care and the push by for profit providers to reduce labour costs. The cost savings of increasing Physician Assistants relative to physicians is substantial, however, evidence indicates that Physician Assistants both over-investigate and over-treat patients compared with physicians – in other words, quality of care deteriorates.

As the editor of *Pulse* magazine has pointed out (53) with respect to PAs: in England : 'it boils down to one thing: they are being used because they are cheaper than trained doctors. This replacement of doctors with PAs is a scandal. Not because we are seeing a spike in avoidable deaths or the like (yet). It is a scandal because it is an acknowledgement that lower standards of care are a literal price worth paying for a cheaper service'.

Campaigners should put it to employers that for the sake of patients (and of MAPs), the BMA scope of practice must be adopted and implemented.

References

1. Campbell, D. (2024) 'Physician associates make job harder, not easier, say thousands of NHS medics', *Guardian*, 2 February
[Available at: https://rb.gy/ph5vhs]
2. Keep Our NHS Public (2024) 'Are physician associates a threat to NHS general practice?', 28 February [Available at: https://rb.gy/jafm8z]
3. NHS (2024) 'Be part of a growing NHS workforce as a medical associate professional' [Available at: https://rb.gy/m3cwfx]
4. NHS England (2023) *NHS Long Term Workforce Plan* [Available at: https://rb.gy/c2kdnu]
5. Royal College of Physicians (2024) 'Physician associate students – placement hours'
[Available at: https://tinyurl.com/44f7mfe6]
6. BMA (2024) 'Majority of doctors say the way PAs and AAs work is a risk to patient safety' [Available at: https://tinyurl.com/39c9tetv]
7. BMA (2024) 'BMA calls for immediate pause on recruitment of physician associates'
[Available at: https://tinyurl.com/2tdvsn58]
8. Royal College of Physicians (2024) 'The Faculty of Physician Associates at the Royal College of Physicians' [Available at: https://www.fparcp.co.uk]
9. University of Leeds (2024) 'Physician Associate Studies MSc'
[Available at: https://tinyurl.com/3ctkkd2v]
10. NHS England and NHS Improvement (2020) 'Network Contract Directed Enhanced Service. Contract specification 2020/21 – PCN Requirements and Entitlements'
[Available at: https://tinyurl.com/vrztyfcj]
11. NHS England (2024) 'Arrangements for the GP contract in 2024/25'
[Available at: https://tinyurl.com/3xv6jvfs]
12. NHS (2024) 'SAS Doctors'
[Available at: https://tinyurl.com/4k7t3ye9]
13. Royal College of General Practitioners (2024) 'SAS doctors working in primary care'
[Available at: https://tinyurl.com/mrx7cfbu]
14. BMA (2024) 'BMA survey finds working with

PAs is increasing doctors' workloads'
[Available at: https://tinyurl.com/54ue568c]
15. NICE (2018) 'Evidence review on physician extenders'
[Available at: https://tinyurl.com/378e2d3j]
16. NHS England (2024) 'NHS England's position on physician associates, 7 February 2024 letter to Royal College of Physicians'
[Available at: https://tinyurl.com/yj6j2eys]
17. PA Media (2024) 'Physician associates must be supervised by GPs, says NHS England' *Guardian*, 28 March [Available at: https://tinyurl.com/4df9pj66]
18. Academy of Medical Royal Colleges (2024) 'High level principles concerning physician associates (PAs). Academy consensus statement'
[Available at: https://tinyurl.com/3rha23zt]
19. Royal College of Physicians (2024) 'Physician associates – background to the profession'
[Available at: https://tinyurl.com/y52dd4uv]
20. Royal College of Physicians (2024) 'PAMVR. Physician Associate Managed Voluntary Register'
[Available at: https://tinyurl.com/mr2p6vz6]
21. GMC (2024) 'Who we are'
[Available at: https://tinyurl.com/ymu3jupm]
22. BMA (2024) 'BMA Briefing – Regulation of physician and anaesthesia associates – The Anaesthesia Associates and Physician Associates Order 2024'
[Available at: https://tinyurl.com/mrywmzt3]
23. Health & Care Professions Council (2024) 'Which profession do HCPC regulate?'
[Available at: https://tinyurl.com/c7cc3vc3]
24. Hansard (2024) 'Draft Anaesthesia Associates and Physician Associates Order 2024. Debated on Wednesday 17 January 2024'. UK Parliament
[Available at: https://tinyurl.com/2s4ycpsd]
25. Parr, E. (2024) 'GPs 'do not face huge complexity', claims former health minister ahead of PA debate'. *Pulse*, 26 February
[Available at: https://tinyurl.com/epj8hr26]
26. Keep Our NHS Public (2024) 'Are Physician Associates a threat to NHS General Practice?', 28 February
[Available at: https://tinyurl.com/53uyw2jw]
27. Goyal, D. (2024) 'Physician Associates: the hidden agenda'. Bylines Scotland, 26 March
[Available at: https://tinyurl.com/w9wpz34y]
28. Hansard (2024) 'Physician Associates. Volume 745: debated on Wednesday 7 February 2024'. UK Parliament
[Available at: https://tinyurl.com/2ymzbwm6]
29. Wilkinson, E. (2023) 'Anaesthesia associates: College votes to halt recruitment until review is conducted' *BMJ* 383:p2460
[Available at: https://tinyurl.com/338fx9vj]
30. Royal College of Radiologists (2024) 'Non-regulated professions requesting ionising radiation examinations' RCR, 26 February
[Available at: https://tinyurl.com/wbk584xy]
31. Parr, E. (2024) 'Doctors criticise Royal College's 'disgraceful' handling of PA debate' *Pulse*, 20 March
[Available at: https://tinyurl.com/yh2n8vbb]
32. Kaur, P.S. (2024) Tweet, 18 March, 13:27
[Available at: https://tinyurl.com/49nbnt3n]
33. Clarke, R. (2024) Tweet, 18 March, 12:17
[Available at: https://tinyurl.com/2mhdt9zv]
34. Clarke, R. (2024) Tweet, 18 March, 10:01
[Available at: https://tinyurl.com/3v92j747]
35. Colivicchi, A. (2024) 'GMC asks NHS England to reassure doctors there is "no plan to replace them with PAs"' *Pulse*, 25 October
[Available at: https://tinyurl.com/mprre47a]
36. BMA (2024) 'NHS medical staffing data analysis' 26 April
[Available at: https://tinyurl.com/2wk3epn8]
37. Academy of Royal Medical Colleges (2024) 'High level principles concerning physician associates (PAs). Academy consensus statement' 4 March [Available at: https://tinyurl.com/3rha23zt]
38. O'Dowd, A. (2024) 'Pledge to boost medical training places rings hollow, say leaders' *BMJ* 384:q502
[Available at: https://tinyurl.com/2wf8h5yj]
39. Munro, C. (2024) 'Nearly 700 anaesthetists have training interrupted after cuts' *BMJ* 373:n1213
[Available at: https://tinyurl.com/3pastkx4]
40. Palmer, W., Rolewicz, L. and Dodsworth, E.

(2023) 'Waste not, want not. Strategies to improve the supply of clinical staff to the NHS'. Research report. Nuffield Trust.
[Available at: https://tinyurl.com/49ywd8rx]
41. Keep Our NHS Public (2022) 'BBC's Panorama 'Undercover: Britain's biggest GP chain' showed us why big business has no place in our GP services' 20 June [Available at: https://tinyurl.com/mfkkc57y]
42. BMA (2024) 'BMA Medical Associate Professions (MAPs) survey' February
[Available at: https://tinyurl.com/fy7ypfun]
43. Parr, E. (2024) 'Practice makes GPs redundant in favour of ARRS staff' *Pulse*, 9 January
[Available at: https://tinyurl.com/2s8dmvxs]
44. Pulse (2023) 'Not enough GPs? Thousands of us are now unemployed' 6 November
[Available at: https://tinyurl.com/5yw7k552]
45. Graham, S. (2024) 'Trained GP can't get a job' *Independent*, 19 March
[Available at: https://tinyurl.com/3hs2jzc7]
[Paywall]
46. Woller, S. (2023) 'Length of doctors' training should be slashed from 7 years to fix staffing crisis, says NHS boss' *Mail Online* 22 March
[Available at: https://tinyurl.com/kahrvbhd]
47. Parr, E. (2024) 'NHS workforce plan relies on 'significant' substitution of qualified GPs, NAO warns' *Pulse*, 22 March
[Available at: https://tinyurl.com/4th37azt]
48. MacConnachie, V. (2024) 'Assessing the impact and success of the Additional Roles Reimbursement Scheme' NHS confederation, 1 February
[Available at: https://tinyurl.com/bd2cmjr7]
49. BMA (2024) 'Safe scope of practice for Medical Associate Professionals (MAPs)'
[Available at: https://tinyurl.com/3z4wmvu3]
50. Parr, E. (2024) 'PA body warns of legal action against GP practices using BMA guidance' pulse, 25 March
[Available at: https://tinyurl.com/5uawwz9w]
51. McKee, M. and Brayne, M. (2024) 'Physician associates in the UK: some fundamental questions that need answers now' *BMJ* 384:q699
[Available at: https://tinyurl.com/mry55f47]
52. Walia, B., Banga, H. and Larsen, D.A. (2022) 'Increased Reliance on Physician Assistants: An Access-Quality Tradeoff?' *J. Mark. Access Health Policy* 10, 2030559
[Available at: https://tinyurl.com/89xpr456]
53. Kaffash, J. (2024) 'The cheapening of our health system is everyone's business' *Pulse*, 20 March
[Available at: https://tinyurl.com/dzxdd488]

John Puntis
Co-Chair, KONP
john.puntis@yahoo.co.uk

Conference Report and Reflections

Boards in Times of Change and Challenge
NHS Providers

EC member Eric Watts also sits on his local Trust's Board of Governors. He offers some insights on how governance issues might be improved

'There is no such thing as a perfect organisation. The best we can ever hope for is that an organisation is self-aware, recognises its issues, and deals with them effectively.'

– Bill Moyes, quoted by John Coutts, NHS Providers Blog (1)

NHS Providers is the membership organisation for hospitals and other NHS services; all trusts in NHS England are voluntary members. They have run courses for governors including one attended by some colleagues from the Trust I am on the Board of Governors for, Mid and South Essex (MSE), focusing on effective questioning.

Last July I attended their meeting *Boards in Times of Change and Challenge*, where Professor Graham Martin, director of research at The Healthcare Improvement Studies Institute of the University of Cambridge (*THIS* institute), gave the keynote lecture entitled 'Reading the Signals – Developing Problem-Sensing Boards'. Later in the day there was a session about selecting people with the right attributes and values to put on the board which is more of a long-term issue.

The title 'Reading the Signals' comes from the Kirkup Report on maternity services at East Kent (2) and repeats key messages in common with many previous investigations into major healthcare problems e.g. Mid Staffs and the CQC' 'State of Care Report' (3).

Included in the Institute of Global Health Innovation's report 'What we Know about Avoidable harm in England' (4) is a statement of the clear need to understand safety from the patient's perspective, which will require boards to be more aware of issues that are not reported through standard metrics.

There were many examples of boards not taking effective measures to deal with problems which mostly fell into two categories, one being organisational and the other to do with human factors in group interactions.

Organisational problems – Structural secrecy

This is the way division of labour, hierarchy and specialisation segregate knowledge about tasks, seen as an inevitable feature of large and complex bureaucratically ordered organisations but it can be significantly worsened by the board's dispositions e.g.:

- Tendency to seek out comfort-confirming data.
- Preoccupation with compliance and procedures.
- Incentivising secrecy through insensitive performance management.

Human factors

These are increasingly being recognised to operate both at individual and group levels. Root cause analysis of incidents has shown that people endeavouring to do their best may contravene the rules if they do not understand their purpose

or if they are trying to follow conflicting rules when standard procedures do not cover every eventuality.

Studies on behaviours of groups, including boards, has demonstrated that a need to show support for colleagues can override an impartial analysis or evaluation of different courses of action.

Group think, where individuals wish to be seen as part of the team, can encourage others to make unwise decisions through lack of challenge. A more common occurrence is the Abilene Paradox which describes a situation where a group collectively decide on something that no one really wants due to a wish not to rock the boat (this phenomenon is named after a family went to the Texas town of Abilene for dinner when everyone had a dreadful time and said afterwards that they didn't want to go – just went to keep the others happy!)

The relevance to healthcare is that it can lead to a culture where unsatisfactory performance is tolerated when no one challenges the poor standards.

NHS Providers published 'Organisational culture: problem sensing and comfort seeking' (4). Among those listed were:

- Comfort-seeking is undesirable behaviour characterised by seeking reassurance, by taking undue confidence from the data available, and by the inability or unwillingness to seek out information that might challenge the sense that all is well.
- Culturally, problem-sensing encourages staff to engage in active noticing of where there might be defects, speaking up about them, and ensuring that systems are in place to make improvements.
- As with the collection of 'harder' data, though, it is important not to mistake activity for action. Simply undertaking listening activities or unannounced visits is no substitute for the hard work of analysing and responding to the issues they unearth.
- The willingness of those at the 'sharp end' to speak and of those at the 'blunt end' (senior leadership) to listen exist in a reciprocal relationship.
- The most important role of boards and senior leaders in nurturing positive cultures may be in collating knowledge about variations in performance, behaviour and culture across their organisations, and supporting local leaders in their efforts to improve openness.

> "A more common occurrence is the Abilene paradox which describes a situation where a group collectively decide on something that no one really wants due to a wish not to rock the boat."

In 'Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety' by Gillespie and Reader (5), the researchers analysed 1,110 health care complaints from across England. These showed a familiar pattern with hotspots, i.e. areas where faults frequently occur and blind spots where problems go unrecognised. The take-home message being that there are familiar patterns demonstrating that corrective actions have not been put into effect. They suggest the patient-reported problems are underused and undervalued.

Complaints by patients and carers contain much information that can help to improve services. Nationally complaints vary between one per 1000 and 100 admissions and the majority are upheld but we do not have a good system for extracting relevant information (5).

Analysis using The Healthcare Complaint Analysis Tool (HCAT) revealed unrecognised hot

spots e.g. patients discharged with insufficient information or treatment were 8% of adverse events by case note review but were not reported through the hospitals' incident reporting systems (6).

Compartmentalisation, i.e. rigid definitions of incidents and how they are viewed by staff, can lead to under-reporting when compared with the patient narrative. This is particularly the case with continuity of care problems where the patient will usually be the only person aware of all issues on their journey.

Under-reporting – Errors of omission are easily under-reported if staff are unaware of what they have missed. Errors may be identified and corrected and therefore not be considered worthy of reporting but could give valuable near miss data.

Incident reporting requires good safety culture and enthusiastic staff with sufficient time.

The authors state: 'Moreover, it is somewhat paradoxical to rely on staff embedded within a culture to self-report on that culture because the culture itself shapes the practices of reporting' (6). This could also be seen as asking people to mark their own homework and is relevant to MSE given the low confidence in staff that their managers have shown in their concerns as revealed in the staff survey.

The authors recommend benchmarking, being aware of the limitations, and that it should be conducted in a spirit of continuous improvement.

In my experience as a governor, the data presented to the QGC and to the board meetings is mostly prepared by our own managers and is therefore selective. The patient experience (mostly not captured) is a significant underused resource. In an American study the items which correlated most highly with patient satisfaction with the quality of communication with nurses and their response time (7). These questions are not part of our normal repertoire.

Professor Martin's suggested answer to this is Cultivating (collective) chronic unease e.g. by

creating safe spaces to:

- Advance psychological safety
- Allow people to say the unsayable
- Mitigate structural secrecy.

There is a pithy summary of the Mid Staffs enquiry published in the *BMJ* (8):

> **'The overall findings reported here could be restated as the proposition that disaster-provoking events tend to accumulate because they have been overlooked or misinterpreted as a result of false assumptions, poor communications, cultural lag, and misplaced optimism.'**

The author describes how the causes of disasters can be traced back through what he describes as an incubation period, familiar to all hospitals which are busy with increasing demand and limited resources. A key factor amongst limited resources is the amount of time boards have to take note of the early warning signs.

This means hospital boards must grapple with three key interpretive challenges: how to ensure attention remains focused on finding gaps in current knowledge, how to monitor for the early and weak warnings of risk, and how to routinely investigate the system-wide causes of healthcare failures.

There is a frequent finding:

'Critically, it is the shared beliefs, collective assumptions, cultural norms and patterns of communication across organisations that shape what information is attended to and how it is interpreted and communicated – and most importantly, what is overlooked, discounted and ignored. Organisations can be defined by what – and whom – they choose to ignore.'

In 'Organisational trust: the keystone to patient safety' (9) by Jenny Firth-Cozens there were four key messages:

1. Organisational trust is essential if we are to learn from error and improve patient safety.
2. The concept of trust is particularly complex in health care, but these complexities must be addressed and the context of health care appreciated.
3. Organisational factors including the characteristics of leaders have been shown to increase trust.
4. One untrustworthy act can upset years of hard work in getting trust established.

It is interesting to note that this is from an article in 2004 when the author worked in Northumbria which is now recognised as delivering exceptional healthcare. To put the fourth point in plain language, it is important not to shoot the messenger who brings unwelcome news.

This means those of us aware of issues must ensure they are on the agenda.

The NHS providers effective questioning module gives useful advice: "Listening skills and questioning styles are explored along with how to frame effective questions and challenge within the context of the governor role."

In the course I attended they drew attention to the need to ask follow-up and supplementary questions if the original question is not answered, something that we seldom have time to do in the limited time governors are allowed for questions in the formal meetings.

My summary of these articles is that boards have limited time and it is too easy to concentrate on hearing encouraging news than to get to grips with problems which may not appear to be important or urgent. The solution is greater objectivity and paying attention to the developing themes. This theme is developed further by safety specialists e.g. Resilient Healthcare Net, quoted in NHSE 'Safety culture: signpost to safety, learning from best practice' (10). They frequently emphasise the importance of reporting, listening, recognising patterns and trends and taking effective action which may be revising protocols, retraining staff for both.

"Boards have limited time and it is too easy to concentrate on hearing encouraging news than to get to grips with problems which may not appear to be urgent."

In my opinion these issues apply to MSE where I have often heard dismissive responses to expressions of concern. Frequently we hear comments to the effect that problems have been dealt with or will be sorted soon. Frequently issues are dismissed as being someone else's problem such as a different committee, or the problem is the fault of the outside world.

The director of *THIS* Institute made a useful comment: 'Stop admiring (or being awed by) the problems and start investing in the evidence to solve them' which is particularly apt to one of MSE's legacy problems, e.g. the thousands of unsent clinic letters. This does not appear in the main metrics and has been brought to the attention of the service users committee by typists.

There are clear implications for patient safety including serious incident reports where

medication was not started by the GP in time. Successive senior managers have promised action that has not materialised e.g. new IT systems or blamed doctors as the major problem. This is a multifaceted problem characterised by occasional short-lived improvements but there has been lack of ownership at a high enough level to make effective change. I could give other examples.

Amongst the barriers to change are that patient concerns are under-represented as most patients are reluctant to complain. Most people, including governors, feel a genuine sense of loyalty to the hospital and do not wish to be seen to be criticising hard-working staff. When Lord Prior (currently chair of NHSE) and Sir Mike Richards, chief inspector of hospitals for the CQC, visited Basildon in 2014 they joked that everyone loves and defends the local hospital irrespective of how bad it is.

"Amongst the barriers to change are that patient concerns are under-represented as most patients are reluctant to complain."

We all want the best for our local hospital, we want it to succeed – for the common good and for us personally. It can be distressing to look at evidence of problems and we too easily reassure ourselves by assuming the problems are being taken care of.

The patient story at the start of board meetings is an underused resource as there has been insufficient attention to broader issues i.e. how many patients have similar experiences and I have not seen follow-up studies to show improvement to prevent similar cases.

Patients are an underutilised resource, the NHS has introduced Patient Activation Measures to help assess the degree of engagement patients have with managing their own and engagement with their providers. They report an association between higher activation and improved health outcomes, as well as lower costs (11).

An issue for the QGC is the sheer volume of work it has to handle resulting in long meetings and the only governor input is a question at the end. It is not uncommon for key members to have left the committee at this stage.

Reports to the QGC indicating unsatisfactory performance do not always result in effective action. The Non-Executive Directors (NEDs) do not have the requisite knowledge to deal with specialist services and need to use external expert reports. Implementation of the reports requires further scrutiny and when this has not happened unsatisfactory services continue.

Meetings could allow more time for discussion of relevant problems through wider use of exception reporting. Giving governors more time to comment and question would help the NEDs to benefit from the insights gained by users of the services.

CQC reports often result in an expression of surprise even when they draw attention to matters that have already been identified by governors e.g. failure to implement learning from mistakes. This helps make the case that the boards could benefit from taking note of governors' observations.

Confusion about where our loyalty lies

It is governors' duty to act in the public interest and on behalf of their constituents. John Coutts of NHS Providers has blogged about this: "Dissent is often taken too often for disloyalty" stating "Back in 2002 Jeffrey Sonnenfeld, in his article 'What makes great boards great' (12) identified the importance of developing a virtuous cycle of respect, trust, and candour."

I see the challenge now is improving on last year's draft *Working Together* to specifically address how we can enable governors to speak up and contribute to that virtuous cycle. One quick

fix would be putting items of concern onto the Council of Governors (CoG) and Non-Executive Directors (GNED) agendas.

One item I prioritised last time was the importance of a reporting culture to allow learning from minor issues and near misses in addition to the serious incidents that are reported to QGC. We have ready-made exemplars from other industries most notably aviation.

One example here is the case of Martin Bromiley, an airline pilot whose wife died because of a medical accident. He went on to found the Clinical Human Factors Group (13), which is a good source of relevant useful material.

In conclusion I found NHS Providers to have identified key issues, many of which are especially relevant to MSE and that we know must hold the NEDs and boards to account to deliver the necessary actions.

References

1. NHS Providers (2023) *Organisational Culture: Problem-sensing and Comfort Seeking*
[Available at: https://tinyurl.com/4cdzedbf]
2. Kirkup, B. (2022) *Reading the signals. Maternity and neonatal services in East Kent – the Report of the Independent Investigation* (the Kirkup Report). House of Commons
[Available at: https://tinyurl.com/y67shzkd]
3. Care Quality Commission (2023) State of Care 2022-2023
[Available at: https://tinyurl.com/3sz8udrv]
4. Institute of Global Health Innovation (2022) National State of Patient Safety 2022. What we know about avoidable harm in England
[Available at: https://tinyurl.com/2v446x7k]
5. Gillespie, A. and Reader, T.W. (2018) 'Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety' *Millbank Q* 96(3):530-567
[Available at: https://tinyurl.com/2jrwymeu]
6. Baba-Akbari Sari, A., et al. (2007) 'Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review' *BMJ* 334 334:79
[Available at: https://tinyurl.com/3ukx4dex]
7. Manary, M.P., et al. (2013) 'The patient experience and health outcomes' *N Engl J Med* 368(3):201-203 [Available at: https://tinyurl.com/44apaphr]
8. Macrae, C. (2014) 'Early warnings, weak signals and learning from healthcare disasters'. *BMJ Qual Saf* 23:440–445
[Available at: https://tinyurl.com/3jrmkt7c]
9. Firth-Cozens, J. (2004) 'Organisational trust: the keystone to patient safety' *Qual Saf Health Care* 13:56–61
[Available at: https://tinyurl.com/ycyndfa3]
10. NHS England (2022) 'Safety culture: learning from best practice'
[Available at: https://tinyurl.com/bd7tx5ef]
11. NHS England (2018) 'PAM implementation guick guide' [Available at: https://tinyurl.com/46w83mja]
12. Sonnenfeld, J.A. (2002) 'What makes great Boards great' *Harvard Business Rev* September
[Available at: https://tinyurl.com/2ukpcv42]
13. Clinical Human Factors Group (2024) Home page [Available at: https://chfg.org]

Eric Watts
eric.watts@btinternet.com

Obituary

Jenny Vaughan

Dr Jenny Vaughan died in March following a long illness with cancer. She was 55.

She had been a member of DFNS for many years, and was also a founder member and former Co-Chair for Doctors' Association UK (DAUK).

A passionate campaigner, Jenny was most widely known for her pioneering work to reform the law on gross negligence manslaughter (GNM). The quoshing of the conviction of David Sellu for GNM in 2016 followed a campaign spearheaded by Jenny. She was also instrumental in supporting Bawa-Garba in successfully overturning the GMC's decision to remove her from the Medical Register in 2018.These high-profile cases were two of many which Jenny helped with, and many members of DAUK have left their touching tributes to Jenny indicating just how far her work went, and how many doctors she helped (you can see this at: https://tinyurl.com/yc27x76m).

Jenny was born in Bristol and qualified from Nottingham University in 1992, specialising in neurology and becoming a Consultant.

She combined her work in the NHS with political activity, serving as a local Labour Councillor in Fulham from 1998 to 2006. During Covid, she helped create an app which allowed doctors to report shortages of PPE.

In 2018 she received the *BMJ* editor's award for 'speaking truth to power', and the British Association of Physicians of Indian Origin (BAPIO) gave her an award in acknowledgement of her support of BAME doctors. She was given an OBE in 2019.

She met her husband Mat at University and they married in 1993.They had two sons, Jonathan and Christopher.

On a personal note, I worked with Jenny for several months in her role as DAUK Co-chair. What shone through, for me, was her determination, which was so obviously grounded

in compassion and a driving sense of justice, especially for her colleagues and the NHS. Her motivation was inspiring, even though it was apparent that her health was starting to fail her. It did not diminsh her will to persist or undermine her willingness to keep campaigning for as long as she could.

I am proud to say I worked with Jenny, and was saddened to hear of her passing. She is survived by her husband and sons.

Alan Taman
healthjournos@gmail.com

Book Review

Exposing NHS Skeletons: Blueprint for Better Healthcare
(£8, available via Amazon, paperback)
Mark Aitken, 2024, 100pp.

This book, by Mark Aitken, a DFNHS member, who has written extensively about the NHS, and whose book, *Who Cares – Conflicts of Interest*, was reviewed in a previous edition, weighs in at just over 100 pages and, true to its title, describes many of the problems that the NHS has encountered over the past 76 years.

As with his previous book, this one provides a lot of fascinating detail particularly of how health was organised and managed prior to the formation of the NHS. He has now added more up-to-date issues including the development of the Physician Assistant role; originally developed in the USA to fill a medical staffing gap in their 'charitable' public hospitals, and now being promoted in the UK to plug the gap in our medical manpower.

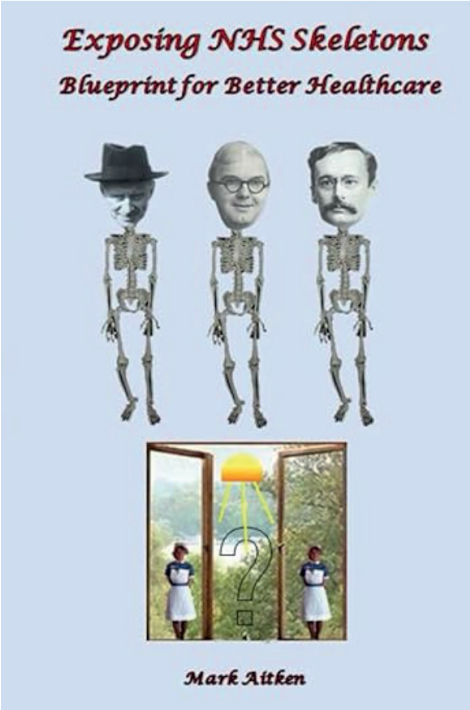
Mark describes the politics and horse trading that Nye Bevan had to go through to establish the NHS, how successive governments have moved away from the founding ideals; and how many doctors have used the service to their own personal advantage.

In the six pages of the preface, he describes the limitations of our political system, with its emphasis on short-term electioneering vote-catching, instead of establishing a solid and secure health system.

This is a quotation from the preface, in order to introduce us to his approach, in which he compares the NHS to a charabanc with all of us on board:

'The roadmap has become a convoluted and tangled web of narrow by-roads leading towards a cliff edge:

1. Do we believe that taking a few more off-road diversions on that road to perdition will somehow avert the inevitable fall off that cliff?
2. Why not turn around and head back, along the road, peeling off those toxic amendments, act by act, until we are in a position to renegotiate the legislation?
3. Alternatively, this vehicle could turn off at the next junction, persuade the passengers to alight, and start a new journey in a new vehicle?'



Naturally he champions option 3.

There is a wealth of knowledge within this book, and authentic autobiographical detail making

insightful observations.

In addition to illustrative case reports, he has described how finances have been manipulated in respect of doctors' salaries, the purchasing of services, and the sale of NHS property.

He proposes many changes, including, starting with the removal of all the political handicaps which have paralysed general practice, and rebranding these doctors as Family Doctors (FDs); emphasising that patient related information belongs to the patient and nobody else; and a ring-fenced funding system which relies upon a new tax.

There is a lot with which many doctors would agree, particularly in respect of his description of patients' records, proposing a new system, where this essential database is held at the FD's surgery.

He sees the majority of services under the new system being free at the point of delivery, but with the option for patients to go private. Consultants, looking for private work, would not be able to work in the new hospital system, but work instead in alternative hospitals, thus preventing the way in which NHS Consultants have in the past been able to moonlight, or manipulate waiting lists.

There are plenty of provocative suggestions and sometimes the intemperate language, (bozoland), could annoy some readers.Here are the first five summary points that he makes in his concluding chapter:

1. Sort out General Practice. Remove the burdens of targets and pointless political incentives. Enrol the new FDs.
2. Get the IT community to sort out the healthcare database, and show that they also have social consciences.
3. Declare bankrupt those secondary care facilities with existing debts, and take over their debts and workforce.
4. Take those Hospital Consultants who wish to continue serving the public, and enrol them as full-time employees, but with no private health related source of income.
5. Reinvigorate Public Health as a centre of disease prevention, screening and community protection.

Eric Watts
eric.watts@btinternet.com

EXECUTIVE COMMITTEE : Elected at AGM 2023

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

Dr Arun Baksi
General Medicine/Diabetes,
Isle of Wight
01983 883 853
07786 374886
baksi@baksi.demon.co.uk

Dr Morris Bernadt
General Adult Psychiatry,
London
020 8670 7305
07510 317 039
mbernadt@hotmail.com

Dr Chris Birt
Public Health
07768 267863
christopher.birt75@gmail.com

Miss Helen Fernandes
Neurosurgery, Cambridge
haatchy1966@gmail.com

Dr Andrea Franks
Dermatology, Chester
0151 728 7303 (H)
Roger.Franks@btinternet.com

Dr Mike Galvin
Haematology, Wakefield
01784616649
drmcgalvin@hotmail.com

Dr Alison Hallett
Trainee, Leeds
alisonelizabeth@live.co.uk

Mr Colin Hutchinson (Chair)
Ophthalmology, Halifax
07963 323082.
colinh759@gmail.com

Dr Malila Noone (Secretary)
Microbiology, Darlington
01325 483453
malilanoone@gmail.com

Dr Maureen O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

Dr Peter Trewby (Treasurer)
General Medicine/
Gastroenterology
Richmond, North Yorkshire
01748 824468
trewbyp@gmail.com

Dr Eric Watts
Haematology,
Brentwood, Essex
01277 211128
eric.watts4@btinternet.com

Dr David Zigmond
General Practice/Psychiatry
London
0208 340 8952
davidzigmond@icloud.com

Dr Pam Zinkin
Paediatrics, London
02076091005
pamzinkin@gmail.com

Communications Manager (Hon. member, non-voting)
Mr Alan Taman
07870 757309
healthjournos@gmail.com

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.

Address for correspondence:
19 Northolt Grove
Great Barr
Birmingham B42 2JH

Coronavirus was never the only threat...

- The NHS is not safe.
- 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.

We've been campaigning to protect the NHS for almost 50 years. Because we believe in it. Help us save the NHS.

www.doctorsforthenhs.org.uk

@Doctors4NHS