DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

AGM 2024: Speaker Reports and Future Action

OCTOBER – DECEMBER 2024

CONTENTS

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Managing Editor – Alan Taman
healthjournos@gmail.com
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- Save the date
- DFNHS AGM and Annual Conference
- Thursday 16th October 2025
- Bedern Hall, York

AGM and Conference 2024:

Wednesday 23rd October
The Town & Country Planning Association London

Opening address: Colin Hutchinson, Chair

[All of the AGM reports can be downloaded from **https://tinyurl.com/d9rjdtb6**]

We have been through a turbulent period in national political life, during which the NHS has seen continuing restriction of the resources that it requires, both in terms of revenue for day to day spending, but also, crucially, capital spending on buildings, equipment and information technology, accompanied by deteriorating public satisfaction with the services that are available to them. With the election of a new government and the electoral mandate that should allow their continued period in office for at least 5 years, it is more important than ever that they are held to their manifesto pledge to "Build an NHS fit for the future: that is there when people need it; with fewer lives lost to the biggest killers; in a fairer Britain, where everyone lives well for longer." Achieving this pledge is one thing: how they approach the task is vitally important.

Members of DFNHS can play an important role in trying to influence policy development, as individuals, through participation in DFNHS and through membership of other campaigning and professional organisations. DFNHS exists to extend support to our members to help them in these various aims.

There have been some encouraging early steps, such as the resolution of the junior doctors' strike, moves to restore confidence in public sector pay review bodies, and the extension of the Additional Roles Reimbursement Scheme to allow this funding to be used to employ new GPs, rather than being restricted to employment of Physician Associates and Pharmacists. It does seem that concerns that "reform" of the NHS could indicate a fundamental change to the NHS business model towards an insurance-based system can be allayed for the time being, backed up by a clear statement in the Darzi Review.

At the same time, concerns have been raised about the influence of those with an interest in increasing the opportunities for commercial interests in accessing public funding to embed themselves long-term in the delivery of care, rather than increasing the capacity of the NHS to provide that care, coupled by a nagging suspicion that some reincarnation of Private Finance Initiatives could be seen as the means to find the necessary capital investment.

We will probably have to wait until the multi-year Public Spending Review due to report in Spring 2025, before the picture becomes clearer. It is important that we use this time to join with others to make the strongest possible case that any additional funding is used to build up the capacity of NHS services, that the Chancellor's pledge to insource public services is kept, and that progress is made on addressing the social determinants of health.

We need to make the case as strongly as possible that the NHS be openly accountable to the public and should not only be funded from general taxation, but that the tax system needs to be truly progressive and, crucially, that the

foundations of our NHS are much stronger when they are based on the concept of public service, rather than driven by profit-seeking.

While remaining non-partisan, we have always understood the need to engage with the political process and our elected representatives, because the NHS was created by the political process and can only be sustained through political support.

It seems to be increasingly difficult for campaigning organisations to gain the ear of our parliamentary representatives, while there exists a lobbying industry to promote the interests of those who would exploit the NHS for commercial or ideological purposes. I encourage all members to seek to build a relationship with their constituency MP, to ensure they are as informed as possible about the way in which the NHS works and how their role as policy-makers is having a real impact on the service received by their constituents, for better or worse. I am always happy to assist members in working with local MPs, whenever the opportunity arises.

Over the past year we have expressed our views on the misguided broadening of the scope of practice of Physician Associates and other Medical Associate Professionals, through letters to the Royal College of General Practitioners and to the new Secretary of State for Health. There needs to be a much greater awareness of the value of a comprehensive general medical education for all doctors, no matter in which discipline they eventually choose to practise, and that sense of value and the obligation that flows from it may not always be sufficiently recognised by some doctors themselves.

DFNHS continues to have strong links with Keep Our NHS Public, with at least four of our members also being members of KONP's Executive Committee. I once more urge members to make links with their local KONP group, because the support of clinicians can be valued warmly by campaigners.

DFNHS joined with 15 other groups to present evidence to Parliament's Health and Social Care Committee Inquiry into NHS leadership, Performance and Patient Safety, focussing on ways in which the NHS disciplinary process is both ineffective and prone to abuse, work that has been promoted over a number of years by Executive Committee members Arun Baksi, Malila Noone and Helen Fernandez. In addition, we have links with Doctors' Association UK and have contributed to some work on the outsourcing of ophthalmology services to the private sector with both DAUK and the Centre for Health and the Public Interest. DAUK has extended an invitation to all members of DFNHS to attend a conference in memory of their founder member Dr Jenny Vaughan in London on 17th May. [*At AGM the importance of further collaborations was agreed.*]

Individual members are also performing valuable roles through other bodies, including the first award of the Royal College of Physicians' Eric Watts Award for Excellence in Patient Care and Patient Engagement. Eric served many years as Chair of DFNHS and continues as a member of the Executive Committee. The winner was the Lincolnshire Living with Cancer Programme.

DFNHS could be a much stronger and more effective advocate for our message that service must come before profit, as detailed on our website. There continues to be a slow reduction in membership numbers. An increasing proportion of our membership have retired from clinical practice, so it becomes impossible to recruit colleagues within the workplace. Further, our ability to draw on examples drawn from current practice in shaping and making our arguments is weakened. We need to be confident that the issues on which we are campaigning are reflective of the current priorities within the NHS [*at AGM it was agreed to establish how many members were now retired, and to contact those still working to ask them to provide up-to-date insights into issues affecting current practice*].

Our attempts to attract younger members through the Peter Fisher Memorial Essay Prize have resulted in some fine contributions, providing an insight into the factors shaping the next generation of doctors, but have not resulted in many new members. Reducing membership

subscriptions have reduced our ability to give financial support to the work of other bodies.

The sustainability of our Annual Conference is also called into question. It is a significant item in our organisation's expenditure and when the number of attendees is low, it becomes less realistic to invite high-profile speakers, even though a fairly comprehensive account of their presentations is published in this Newsletter and so is made available to the membership, as well as to the general public. The quality of the material presented in these reports has usually been excellent and of wide interest, so it is difficult to understand why attendance has not been greater. Previously, attendance has been higher when the meetings have been held in London, but that was not the case this year. Is there a point at which we should consider switching to an online AGM and conference? [*Agreed at AGM to defer this to EC.*]

All organisations should also consider succession planning, which includes developing opportunities for enthusiastic members, with new ideas, to become involved. I have had the privilege of being Chair since 2018 and a fresh approach is probably overdue, so we need to be taking steps to ensure a transition in due course, and that would be best achieved through membership of the Executive Committee.

We would welcome members with a desire to become more actively involved to put themselves forward for membership of the Executive Committee and, if you are considering this, please get in touch with myself or any other member of the Committee – our phone numbers are on Page 39.

Treasurer's Report: Peter Trewby, Treasurer

Summary

Total amount in feeder account on 18/10/24 £4,920 and £3,500 in our current account.

Our principal outgoings over the past 12 months have been £900 for Junior Doctors' essay prize, around £470 quarterly magazine costs and £1000 pcm to our Communication and Publicity manager and AGM costs. We have not felt able to give any money this year to KONP, or other recipients.

Figures 1 and 2 show fluctuations in our deposit balance over the past 12 months and over the past 5 years respectively.

Subscriptions

Since our last AGM meeting, we have lost 37members (5 known deaths; 21 'no reply' despite repeated requests; 9 various other reasons). This year, we have gained 2 new members including 1 trainee (from this year's essay prize). Over the past 5 years we have averaged losses of 31 per year and gained 4 new members per year. We currently have 523 members including 15 trainees (down from 28 last year) and 28 retired or active GPs.

£700 Essay Prize

This year's title was "Non-medical practitioners on the front line – a help or hindrance to good practice?". *The Journal of the Royal Society of Medicine* published two of last year's submissions ("Is the 1948 model of healthcare still appropriate?") but felt unable to this year because the topic was so fast moving. This year's winners were Vanessa Kocia first, and Luke Solomi and Luke Austen equal second. Suggestions please for next year's essay title.

AGM and cost pressures

AGM: Total costs to date this year £245 for lunch, £363 for venue hire, postage and stationery £830. [*Ticket sales recouped £429.67.*]

In summary

No immediate pressing financial pressures but we need to be aware of our reduction in numbers.

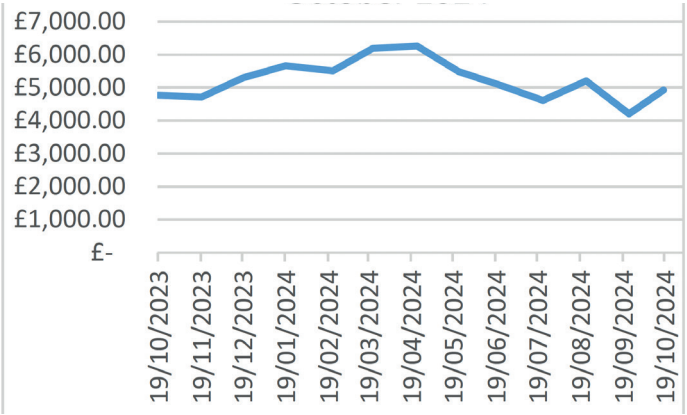

Figure 1 This year's balance, Oct 2023 - Oct 2024

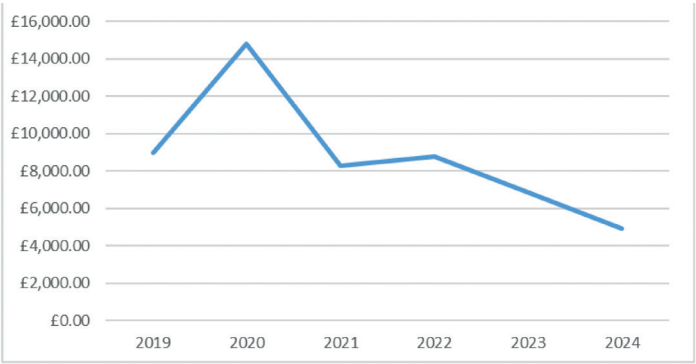

Figure 2 Historic feeder account balance Sept 2019-24

Communication Manager's Report: Alan Taman

Alan thanked the meeting for the opportunity of working for DFNHS and echoed Colin's thoughts on the importance and effectiveness of continuing collaboration with other groups.

Overview

This past year has seen a change of government as the problems faced by the NHS have continued to grow. DFNHS has worked successfully with other campaign groups (chiefly KONP and We Own It) on bringing the NHS's real problems, as opposed to those promoted by the last government, to the attention of the public during the run-up to the election and on other occasions.

The new government has started to make improvements and is turning more to public consultation, which is a vast improvement, but there remain fundamental concerns about how the government perceives the NHS, which DFNHS should continue to consider and act on. These include:

1. The role of MAPs (PAs, AAs, etc). .
2. The use of IT and artificial intelligence.
3. The continued reliance by the NHS on the private sector and what could be a growth in its use by the NHS.

Newsletter and media

The newsletter remains successful as a quarterly and most members prefer to receive it in printed form, which inevitably attracts delivery costs. Authors and interviews of people from outside the organisation continue to be published and add to the perspectives and discussion members have. The membership as a whole value this form of update.

DFNHS has continued to receive enquiries from national journalists. Last year this included queries from the *Guardian, Observer, Daily Mirror, Daily Mail* and the BBC. With more organisations commenting on the NHS coverage tends to be spread out more amongst them. But DFNHS continues to be regarded as authoritative. This puts us in a good position to make our points when we need to, which reinforces our reputation with journalists. We punch well above our weight.

The website remains useful as the principal online communication channel. Blogs have averaged monthly but more recently as the new government has started making plans for the NHS. Our 'X' stream continues to hold steady at just over 2,000 followers (good for a group of this size) and tweets are posted on any issue that relates to the group's objectives. The general quality of 'X' has degraded since taken over by Musk but DFNHS does not engage in unpleasant or baseless exchanges as policy so this does offer some safeguard against trolling or abuse.

Suggested actions

DFNHS remains in a strong position to formulate evidence-based approaches then act on them. This can be done by supporting individual members, acting on our own as a group or increasingly in collaboration with other groups.

We remain a 'strong voice' as a campaign group but, as the Chair's report makes plain, in order to say the right things we need to be focused.

Keep Our NHS Public Report: John Puntis, co-chair of KONP

Summary

- We have continued to grow in prominence, with increased media presence, and requests for interviews.
- We have strengthened our position as the lead NHS campaign. KONP membership continues to grow (total membership now about 1,000 nationally) slowly.
- Our online newsletter now has a following of about 30,000 monthly, many of these non-members. [*Agreed to increase links between this and the DFNHS newsletter.*]
- Health Campaigns Together has been developed within KONP.
- We have established working groups on Integrated Care Systems; patient data; General Practice; mental health; and ear wax removal.
- A pathfinder hospital group met periodically to review and highlight the non-progress of the 'New Hospitals Building' programme, committed to in the Labour manifesto but quickly relegated to 'not funded therefore subject to review'.
- Groups continue to be active around defence of migrants, working with Patients not Passports and others.
- We have highlighted the problems in NHS dentistry as well as concerns relating to Medical Associate Professionals.
- Together with others, we challenged the sale of former AT Medics practices by Operose to Twenty 20 Capital, a private equity company, with the result that contracts were stripped from practices in Islington and Camden.
- We have been working closely with other

groups, such as We Own It, the Socialist Health Association, Doctors in Unite, the People's Assembly (PA) and the 99% Organisation. In December, we will join with the 99% for another meeting in parliament to make the case for a publicly funded and provided NHS. KONP joined the rally organised outside Labour Party conference by the PA, and provided a speaker on maternity services (Felicity Dowling)

- Day of action 9th March, with 20 groups organising events; 5th July events to mark NHS birthday
- Leafleting of National Theatre and cinema performances of 'Nye' around the country
- Six months ago we set up a monthly online meeting for members and supporters to share information about campaigning. These have been welcomed and are well attended.
- We remain primarily a broad-based campaign seeking the successful reinstatement of a public NHS, including a public health system.

Central team

Our small team comprises Head of Campaigns, Tom Griffiths (4 days/week), who has played a major role in growing our campaigning work. Our campaigns officer Lucy Nichols (4 days) is also excellent as is Finn Smith (3 days), our national administrator. Samantha, our press and media officer (10 hours/week) continues to build positive and rewarding links with the media and press; we have a sessional bookkeeper. Our website (https://keepournhspublic.com/) is maintained currently with voluntary support.

Expanding our resources further

We are struggling with increased costs. The only way we can grow our organisation and be more effective is by bringing in more donations. Please consider making a regular commitment as an individual if you do not do so already. KONP's campaigning is now more important than ever with the current state of crisis in both health and social care and the new government indicating policies that suggest our long-term objectives are unlikely to be realised.

John thanked Colin for joining the KONP Executive. He also thanked DFNHS for its support and looked forward to continue to work closely together.

Election of Executive Committee

EC members were re-elected for a further year. Colin urged any DFNHS member who wished to join EC to let him know.

Plans for the Future

These were considered at the culmination of the AGM. Specific points of agreement are noted in the Chair's report.

It was also agreed that further ways of collaborating with other groups would be sought, in particular with KONP, Medact and the Centre for Health and the Public Interest (CHPI). [*Agreed to include a link to this newsletter online in KONP's monthly online newsletter, and communicate with KONP's Working Group coordinators.*]

DFNS remains unique as the only group consisting of doctors which addressed its aims, with the ability to speak from that perspective and engage people from it with conviction. The group had always acted and continues to act to keep its members informed about overarching issues in socialised healthcare while engaging in the political process in a non-partisan way, reassuring members that they do not stand alone in holding these views.

Its membership fees remain significantly lower than other groups admitting only doctors (such as the BMA), which address wider issues such as

Speaker Reports

Better primary care cradle to grave?

Brenda Allen
Chair, Keep Our NHS PublicWorking Group on Primary Care
Compiled by Colin Hutchinson

Brenda Allen is chair of Keep Our NHS Public's national primary care working group, developing policy on a desirable future for primary care, and a member of Haringey KONP which has just campaigned successfully for the termination of the Operose primary care contracts. Having worked in and with the NHS and social care as a family therapist and then developing research and policy, she firmly believes that the best results are obtained when patients and clinicians collaborate.
She is a campaigner and patient representative for primary care and the 111 service, chairs her Patient Participation Group and is the incoming chair of the Patient and Carers Participation group at the RCGP.
With a GP and patient group, she submitted evidence to the House of Commons Health and Social Care Committee's Inquiry into the Future of General Practice in 2022, and written briefings for councillors and MPs.

In the Primary Care Working Group of Keep Our NHS Public (KONP), we often feel it's one step forward, two steps back.

Many people have put so much effort into campaigning, writing and engaging with the political process, but in most parts of the country, primary care is in bad shape.

We all know the problems: we have a primary care service that has been defunded, deskilled, fragmented, outsourced, devalued, and overwhelmed by the demands placed on it. We know the solutions: raising morale, improving staffing levels, adequate funding, tackling inequality, achieving value for money and insourcing, combined with leadership by a clinician and patient alliance. But how to shift the focus of public debate, to improve understanding of the potential of primary care, and gain traction to ensure its potential can be realised?

A clue may lie in Wes Streeting's utterances. When asked recently in a radio interview about campaigning groups that include doctors, he responded that doctors may complain about his plans to use the private sector, but then rush off to their private practices. In contrast, Wes Streeting says he is the patients' champion, and achieving value for money is crucial for the government, so might campaigners achieve more by emphasising those two issues?

One step forward, two steps back

One step forward. On 3rd September 2024, North Central London (NCL) ICB decided to terminate all its Operose GP contracts on the grounds that healthcare and staffing at one of the practices was unacceptably poor, and that to continue with the contracts would seriously undermine patient and public confidence in the system.

The background was Operose's sale of its GP practices in December 2023, having bought nearly

60 of them, covering 640,000 patients, mainly in London, from AT Medics in 2021. The sale was apparently because of low profits, despite the 14% premium per patient paid to holders of Alternative Provider of Medical Services (APMS) contracts.The new owners were T20 Osprey Midco, a company set up only months earlier, with no record at Companies House, and part of a complex web of companies, including HCRG (rebadged Virgin Care), with a mixed record providing health services, and all owned by Twenty 20 Capital, a private equity company.

AT Medics Ltd continued to hold the contract and knowingly committed a serous contract breach, by enabling Change of Control to be transferred to T20 Osprey Midco Ltd., prior to ICB authorisation, the debt was restructured, and there was poor patient care at one of the practices in NCL.

Patients had been alarmed – if Operose couldn't make a profit, how could a private equity group do so without cuts to staffing and services? So, Haringey KONP and members of a Patient Participation Group (PPG) in an affected practice, submitted deputations to the Primary Care Committee (PCC) and the Joint Health Overview and Scrutiny Committee and met the PCC chair to discuss patient concerns.

However, two or more steps back. The ICB is considering whether to put the contract out to tender again, rather than using their powers under the Provider Selection Regime, to directly award the contract to a local GP Federation, a Primary Care Network (PCN), or a larger practice, all of which would keep these practices within the NHS. If they do go out to tender, it is likely that T20 will submit a new bid, and quite possibly win the contract.

The PCC considers competition can benefit Federations and practices, and cited a recent, almost first, when another NCL practice did win a tendered contact.The £25,000 cost to Federations and practices of employing professional bid writers in order to compete with large commercial companies is not regarded as a problem. A consideration for ICBs is the recent example of NHSE overturning, on appeal, an ICB direct award, a situation they wish to avoid.

Worryingly, none of the other ICBs have terminated their contracts despite being subject to the same contractual and financial behaviour by Operose; some say that this is in the interest of continuity of care; some say they may reconsider it when the contracts come up for renewal, so there is still a lot of work to do. Also HCRG has recently been awarded some huge contracts, worth £1.3 billion for adult healthcare in Swindon and £300,000 for children's healthcare in Surrey.

Does this outsourcing of primary care to private companies represent good value for money or better patient care? No! Evidence indicates that ownership-type influences care quality, health outcomes, and cost. NHS provision and contracts, rather than outsourced private provision, generally deliver better results, is more cost effective, and increases productivity (1-3).

Value for Money

Primary care is a special specialism – essential for health, good value for money and the bedrock of the NHS. So why has it been allowed to whither, and be so misunderstood, that some policy makers believe that mega practices, AI, cheaper, less skilled staff and ownership by shadow banking companies (private equity et al.) are good for patients and their primary care?

To be fair, Wes Streeting, and Jeremy Hunt before him, do seem to recognise primary care's value, with one of Streeting's 'Three Big Shifts' being towards more care being delivered by primary care and community health services. However this has not yet been reflected in the spending allocation, nor the halting of some disastrous policies that will further undermine patient care. This is an issue we need to take to the wider public as well as ministers.

'Primary care is the most inclusive, equitable, cost effective and efficient approach to enhance people's physical and mental health', according

to the World Health Organisation (4). It also offers huge benefits to the wider economy (5). Healthcare investment in general gives 4x economic return, but every £1 spent on in primary care yields a £14 benefit to the general economy (6), so good for economic growth, which should be music to Treasury ears.

It is also very efficient. Primary care sees 90% of all patient contacts, for 8% of NHS budget. The OECD average for the proportion of the healthcare budget allocated to primary care is 14%, it's 17% in Spain and Estonia, and 18% in Australia. The UK has 15.8% fewer GPs per head of population than the OECD average.

And how many people realise that a whole year's worth of care by a GP costs less than two trips to A&E?

Primary care – a special specialism

Far from general practitioners being less skilled, they see the undifferentiated patient, a patient presenting for the first time with a new problem, or even a known patient with a completely new and unexpected set of symptoms. This requires excellent skills and knowledge of how the human body functions in health and disease, the wide range of patterns of disease, the accompanying signs and symptoms, and the ability to assess whether these are the beginning of something serious, possibly life-threatening, or not.

Diagnosis of the undifferentiated patient is key to timely, efficient and safe care, delivered at the NHS front door, and this requires a GP. It is not a task that can safely be undertaken by other professionals, except for some physiotherapy, or ophthalmology assessments. This is a crucial message for politicians, NHS managers and the public.

The concept of the family doctor who knew generations of a family and their community, lay at the heart of the NHS, but has become very diluted. Continuity of care is the magic ingredient and comes with important benefits, including increased productivity, with a 5.2% reduction in total consultation demand (7), improved job satisfaction and better staff retention. It reduces mortality, morbidity, A&E attendances and hospitalisations (8). Both over- treatment and under treatment are reduced, as is compliance with treatment.

People grumble that patients don't take the pills they are prescribed, or do their exercises, but if you just see a random member of a team, who you've never seen before and are never likely to see again, then why would you? It's completely different if you see a particular clinician regularly, who makes it clear that they care about you, whether they are a nurse, a physio or a GP.

What happens when demand outstrips supply?

Darzi (9) described the UK as a society in distress, with a growing, older, sicker and more unequal population. The burden of ill health in Britain is high and growing, much of which can be attributed to longstanding health inequalities, exacerbated by austerity policies: poverty, poor nutrition, poor housing, poor working conditions and the stress caused by the precarious situation in which many households find themselves. Healthy life expectancy is falling, particularly for those living in more deprived areas. 7.8 million are on hospital waiting lists and 2.8 million too ill to work. These people all rely on primary care which, overwhelmed and imperfect as it is now, is the only care patients can access, except for A&E.

Additionally, there is a burgeoning bureaucracy including CQC requirements, and reports for the Department of Work and Pensions, plus underfunded task shifting from hospitals, partly due to advances in care, but also the management of patients on waiting lists for diagnosis or treatment, and the Discharge to Assess system, whereby patients are discharged from hospital before their need for community care has been assessed. The latter a response to shortage of hospital beds, as well as the better known, but unaddressed under-provision of social care.

One GP in our group ruefully observed that there was little more demoralising than sitting

opposite a patient when you'd exhausted your own treatment options and there was nowhere to refer them; no longer voluntary provision and hopelessly long hospital waiting lists. The patient knows you've got nothing more to offer, you know they know, and they know you know.

The numbers behind the picture

The scale of underprovision is underacknowledged and underpublicized; it is estimated that soon most appointments will be with non-GPs. There has been a rapid reduction in the number of practices across the country, with 20% fewer practices, affecting particularly rural and poorer communities, which receive 7% less funding than more affluent areas (10, 11).

Numbers of qualified GPs have fallen to 27,662 Full Time Equivalents (FTE): that's 1702 fewer than in 2015. Partners are leaving faster than they can be replaced, with 15,942 FTE: that's 5,713 fewer than in 2015. There is a shortage of about 3,500 GPs. Many of these posts have been filled by Physician Associates and other roles paid for through the Additional Role Reimbursement System (ARRS): at the same time, many qualified GPs are finding themselves unemployed, particularly in the midlands and north of England (12).

The fall in GP numbers, combined with the rapid increase in England's population, has led to practice list sizes rising, often to unmanageable levels. On average there has been a 40% increase. The average size of the list per GP was 1,400 when the President of the Royal College of GPs started her career: it is now 2,293, and 2,560 in London. And there are fewer people working in many of the important disciplines in community health services: 48% fewer District Nurses; 37% fewer Health Visitors and 35% fewer School Nurses. Guess where the unmet need ends up?

There has also been a change in the ownership and scale of primary care. Although only 6.9% of practices are owned by private companies like T20, they tend to be the larger or mega-practices, so the number of patients affected is very much greater. 80.3% are still owned by partnerships and 0.7% are owned by the NHS (12).

There is also the shift to remote access, by telephone or the internet. An NHS manager observed that COVID had enabled plans to drive the switch to remote access, shortening the roll-out time from an estimated 7-8 years to only months.

The 2024 Commonwealth Fund Report shows that the UK has tumbled down the international league tables and now ranks eighth out of ten countries for safety, prevention, life expectancy, preventable deaths and outcomes (13). In 2015, Mark Britnell (14), in his survey of international health systems, concluded that the main difference between the UK and better performing systems, is that they spend much more per head of population, not their different organisational or financial models. That is still the case, as demonstrated in Appendix 3 of *The Rational Policy-Maker's Guide to the NHS* (15).

Also under-appreciated is that large parts of primary care are not free at the point of delivery. Problems with eyes, ears, feet and teeth have largely slipped from NHS provision. And, if you're dying, the NHS only funds 37% of hospice care, with the gap filled by charitable donations. We have all let part of primary care drop off the radar: we just accept that unquestioningly, and the worry is that the rest of primary care could go the same way.

What about the patients?

As Paul Johnson from the Institute of Fiscal Studies noted, 'The actual priorities of actual patients, play… little role in the byzantine world of health policy and delivery' (16).

According to the most recent NHS GP Patient Survey (17), nearly three-quarters of patients reported a good experience of primary care (which, of course, means that one quarter did not). Nearly 60% were seen within a few days, which does bring the government's push for same-day access hubs into question. And many patients do

try other options before contacting their GP: 34.3% self-treat, 27.8% use online advice, 15.1% seek help from family or friends, 14.1% go to a pharmacy, and 16% use other sources of advice, so the drive to further promote self-care and divert patients may be misguided.

68.4% of consultations took place face to face, and over 90% of patients felt their needs were met with in-person consultation, and the Patient Association found that remote consultation only worked for 10% of patients (18). Only half reported finding the NHS App and website easy to use, and the other half, who find it hard, are not only the 'usual suspects', ie the elderly and people for whom English is not their first language, as imagined by politicians and NHS managers.

Worryingly, a survey by Healthwatch in 2023 showed that 28% of patients avoided making an appointment because they found it too difficult (19).

And the experience of accessing services out of hours, which is, of course, the majority of the week, was poor, with only 55.9% having a good experience. This is largely a privatised service (14).

Do we know what we want?

About 3 years ago, a group of patients and GPs worked together on a vision for primary care. This formed the basis of a submission to Parliament's Health and Social Care Committee Inquiry into The Future of General Practice in 2022 (20), and subsequently discussions and papers to Wes Streeting and advisers.

Primary care would be designed with patients, run by health professionals, publicly funded and publicly delivered. There would be a one stop shop, single front door to the NHS, except for existing self-referral routes. It would be simple to navigate, attractive to staff, and welcoming and accessible to patients.

Practices would be clustered into health and wellbeing hubs, each serving a population of about 20,000, embedded in communities, within walking distance and with good access to public transport. These hubs would offer a wider range of health and wellbeing services, plus some out-patient services, with more mental health and end-of-life provision. The hubs would share good links, as a network, with services run by the voluntary sector, secondary care, public health and the local council, with services co-located where appropriate. There would be improved links with clinical networks and with universities and colleges for enhanced training and research opportunities. The Bromley-by-Bow Health Centre in east London goes some way to fulfilling this vision.

The hub model would take account of local service strengths, geography, and health needs, to build up patient services, so hubs would look and operate differently in different areas, not all services would be co-located and they could grow organically – rather different from some of NHSE's current plans.

Sticking plasters

Instead of fixing the core problems, the previous government turbocharged policies that risked inflicting more patient misery, and diluting primary care beyond recognition, deskilling, fragmenting and privatising.

These included, increasing physician associates (PAs) from 3200 to 10,000, many of whom work in over-stretched primary care, unable to provide the supervision they require; allowing private companies and private equity companies to buy and sell primary care practices like chips, even when they flout the terms of their contracts; and introducing same-day access (SDA) hubs for 'simple' cases staffed mainly by non-GP's (a sort of 111 service for 24/7), leaving the rest to GP surgeries.

Superficially the idea of increasing staff numbers, increasing same-day access and using the private sector's alleged capacity, may appear attractive, but none are backed by evidence. PAs and SDAs underestimate the complex needs of many primary care patients, and various private public ventures, and private outsourcing have delivered

poorly and left a costly and wasteful legacy, from PFI, and LIFT set up in 2001, through to some Covid procurements.

For PAs, primary care is less well placed to offer the supervision and oversight needed, partly because of the style of working and the issue of the undifferentiated patient. So, far from 'getting it right first time,' which saves time and money, and increases GP productivity, patients are often seen many times, before or even if, the right intervention is offered (21, 22). Larger privately owned practices on APMS contracts, often in poorer areas, tend to employ more PAs and fewer GPs compared with the national average.

The BMA has produced guidance (23) for safe practice for PAs already employed which states that, "this does not extend to seeing undifferentiated patients in any situation." The RCGP broadly supports this stance, and Wes Streeting has announced a review.

The idea of Same Day Access Hubs (SDAs) is also superficially attractive, particularly if you live in a part of the country where it is difficult to get to see a doctor, until you realise that it means further fragmentation of primary care. The hubs will be mainly staffed by non-doctors using an algorithm-based triage system. NW London's adoption of the system met with fierce opposition from patients and clinicians and has been temporarily paused.

Seven more SDA 'pilots', have started, which will evaluate how primary care can better use digital tools to target the most vulnerable; automate complex processes; and risk stratify populations. Is this the primary care we want? The mandated component has apparently been dropped, but the financial carrots and sticks appear intact. Evidence does not support prioritising access over care continuity, and the separating of same-day care from longer term care in general practice. It would be much better to give PCNs the money to improve access and continuity of care in a way that best suits local need and resource strengths.

The oft-used slogan 'free at the point of delivery' is not sufficient to ensure value for money or good healthcare in the short or long term. We do need to learn lessons from social care (98% of care homes forced to close by CQC were for profit), childcare, dentistry and the US healthcare experiences, before it is too late, and challenge the claim private provision is necessary and benefits patients. Evidence indicates it increases mortality – a 1% increase in outsourcing is associated with an annual increase in treatable mortality of 0.38% or 0.29/100,000 deaths the following year (24). Yet 10% of all NHS treatments are with for-profit providers, and more contracts are planned that will be too big to fail or monitor.

Funds deployed in tendering, contracting and extra payments would deliver better value for money if channelled into building capacity in existing practices and developing new ones within the NHS family, perhaps with PCNs, hospital trusts or the newer Employee Ownership Trusts (25).

Will the new government deliver?

There have been some very positive announcements, but also some real concerns. Positive moves include settling the junior doctors' strike, although there are unresolved disputes with GPs and nurses. The funding settlement for revenue spending is better than expected, but half of it will be taken up by pay awards, leaving a real-terms increase of 2%, compared with the 3.8% for 10 years that the Health Foundation estimates will be necessary for the government's plans to be realised.

The increase in funding for capital investment is particularly welcome as are plans to train thousands more GPs, create a thousand more GP posts, more Health Visitors and District Nurses posts, and the provision of a modern booking system and the commitment to face-to-face appointments for all who wish them. These measures should improve the efficiency and safety of the service and reduce some of the frustrations arising when trying to access primary care.

The plan to trial neighbourhood health centres,

with District Nurses, GPs, mental health, palliative care services, physiotherapists working from the same base, bears similarities to our vision, but if overly prescriptive and ambitions, relative to funding, they risk repeating the problems encountered by the earlier Darzi clinics, and if too large in scale, risk remote, impersonal care.

Also positive are incentives to make it easier for a patient to see the same doctor during their treatment, suggesting that there has been recognition of the value of continuity of care, and the long overdue review of the dental contract to give greater emphasis to prevention, and stimulate the recruitment of more dentists providing NHS care.

But there are also some concerns about the direction of travel. The starting point of the NHS as the Preferred Provider has been shelved, despite substantial evidence highlighting the poor value for money and often poor patient care that private outsourcing represents.

The new Community Pharmacy Prescribing Service is intended to reduce the demand on GP practices, but there are concerns about its scope and safety, and the inconvenient fact that many pharmacies are going out of business.

There is a plan to expand the scope of direct referrals, which are already available to optometrists and physiotherapists, to include women with concerns about changes in their breasts. But such concerns are common and there is no evidence that hospitals and diagnostic centres have lots of spare capacity, and so patients who could be better assessed in primary care won't be, and other patients who need hospital diagnostics may miss out. Might it not be more effective to invest in GP services for diagnosis and signposting?

There is a touching faith in the ability of digital technology, reform and the private sector to transform the way the NHS delivers care, but so often these have over-promised and under-delivered. We know how much money was channelled into Connecting for Health, with very little to show for it. Improved IT for patient records, booking systems, and other administration would be beneficial, but needs to balance confidentiality of patient records with ease of access for clinicians working in the many different parts of the NHS. The involvement of commercial companies like Palantir in the Federated Data Platform only sharpens those concerns.

Experience shows reform rarely delivers, but disrupts and delays care. Johnson and Darzi both advocate improving the ability of the current system to deliver. As Johnson remarked, the most success transformation of the NHS for decades was Blair's investment of nearly 7% to match European funding levels.

The Workforce Plan is important, but when you see that, by the end of the 2030s it is planned that there should be 49% more hospital Consultants, but only 4% more GPs you are bound to question how much priority is really being given to primary care.

So what next? Matching services to need

Primary care could do very much more than at present, if it were properly resourced. The Royal College of General Practice talks of 'rescuing' primary care, but the vision needs to be much bolder with a clearly articulated ambition as to what primary care could be, should be and how good that would be for the health of patients and of the economy.

1. The UK's GDP expenditure per head of population has lagged well behind comparable countries for over a decade, and must be raised, as must the proportion of NHS spending devoted to primary care, to match the level of comparable countries, from the UK's pitiful 8%, to the OECD's 14% average This legacy is a mountain to climb for the current government, and this message needs to reach a wider public, still unsure why things are so bad when they are told about the extra funds spent during the pandemic, and tales of falling NHS productivity.

An example of what can be achieved, albeit in a very different country: Costa Rica decided

to invest massively in primary care, because of its poor health outcomes. They made sure of good two-way flows of information between the government and regional boards so they could respond to varying demands. Their population health outcomes improved significantly, allowing them to start to reduce spending on healthcare (26).

2. New funds and staff should initially be targeted to under-doctored, disadvantaged areas, currently receiving 7% less funding than more affluent areas. Primary care can mitigate some of the malign effects of health inequalities.

Targeting will necessitate reweighting the Carr Hill and the ARRS formulae to take greater account of levels of deprivation in different communities, and other measures such as supporting existing initiatives in this field such as Deep End (27,28) and Born in Bradford (29).

The Deep End Movement, started in Scotland in 2009, bringing together GPs working in some of the most deprived communities in the country, to pool their experience, provide mutual support and share good practice.They celebrate the differences that patients bring and work differently with them, rather than trying to make them fit into an NHSE system, which completely fails to accommodate the needs of people ground down by chronic ill health or caring responsibilities and long-term poverty. They coordinate, engage with their community, have good links with universities, and have created centres of good practice, showing what primary care can aspire to (27, 28).

The Born in Bradford project is another that shows the power of networks and collaboration in bringing together research, training and treatment (29).

3. Workforce issues are the priority, with effective measures needed to raise the status of general practice and make it an inspiring, attractive career option, to encourage medical graduates to train in the specialty, and to stay, developing their skills and their practices, and also inspire former primary care clinicians to return.

The future workforce strategy must be evidence based and focus on increasing the training, recruitment and retention of staff key to primary care i.e. GPs, nurses, pharmacists and physiotherapists, counsellors or psychologists. Further extension of PAs into primary care needs to cease and the BMA's guidance on their employment introduced. We need to emphasise the role as complementarity to doctors, not their substitution.

Encouraging and supporting local applicants to local medical schools might improve recruitment in poorer areas, as graduates tend to stay and work in that area, and similarly the development of high-quality medical apprenticeships, as already exist in some areas.

Resourcing research and training opportunities within general practice is important for status and morale eg an expansion of GP with Extended Roles, support to increase the number of training practices which find it easier to recruit GPs, and close links with universities to encourage research opportunities for all staff and expand the primary care evidence base.

4. Settling the GP contract is overdue, and the new settlement needs to ensure good care, NHS terms and conditions for all staff, time set aside for training and meetings, funding for premises and equipment, and also provides sufficient reward for the work involved in running a practice. The original uplift of 1.9% does not cover these costs. One GP in our group, thinking of the extra 14% per patient that comes with the APMS contract, said that if their practice received that, being a partner wouldn't be so stressful, and would also be better for patients.

The cost of premises is a problem, as is space for expanded teams. Darzi pointed out that 20% of GP practices are working out of buildings that were built before the NHS was founded. Costs have risen considerably, including administration charges levied on many practices by NHS Property Services Ltd. Might not England benefit from Scotland's Equity Transfer Scheme which was introduced to phase in a move to GPs no longer owning their premises, which gradually

become state assets, rather than being a liability on the practice, and one of the reasons that many practices close and are sold?

5. The prescriptive roll-out of SDAs should be halted, with PCNs given discretion on how best to improve access and continuity. The BMA guidelines for Physician Associates should be adopted. The awarding of new APMS contracts to private providers should be phased out, with stronger penalties for breaches of remaining contracts. There should be improved support for existing GMS and PMS practices, and the adoption of alternatives to APMS, with NHS bodies or Employee Ownership Trusts, led by health professionals.

6. Now is not the time for a major review or reorganisation, including that of the partnership model; supporting both partnerships and NHS salaried models will be the most cost effective and least disruptive option.

7. Consider basing more primary care provision within or alongside A&E departments, accepting that some patients will always turn to A&E. It would improve access to care for the homeless and the non-resident populations. An example is South Warwickshire GP Federation which set up a primary care service at their local hospital and it deals very effectively with 20% of A&E attendances, avoiding needless patient redirections.

8. Supporting structures do need to be put in place, including a cross-departmental health committee to coordinate health impacting policies and to maintain the focus on primary care and public health. Funding flows to primary care, community services and mental health services need to be locked in. There needs to be much stronger representation from primary care, public health and patients on ICBs.

9. We should be exploring the possibility of a UK Tech model, developing data and other IT services in a collaboration between UK universities and companies; retaining the jobs, expertise and intellectual property benefitting the UK and its public services, as an alternative to the default position of always contracting with multinationals and companies like Palantir, Microsoft and Google.

10. It is also important to recognise the need to confront the powerful forces leaning on government, which would prefer to continue to exploit the pseudo-market in healthcare in all its different aspects and have powerful lobbyists and deep pockets to do so. We need strong alliances between clinicians and patients to argue the case for a primary care system, NHS funded and delivered, that can support us all to lead healthier lives and benefit the economy, and to persuade our elected representatives and the public that it is achievable and to ensure they understand the steps we need to take to make it a reality.

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The NHS: Too Good to Gamble With

Mark E. Thomas
The 99% Organisation
Compiled by Colin Hutchinson

Mark E. Thomas is the author of 99% (1). He has spent most of his career in business; for many years he ran the Strategy practice at PA Consulting Group.
During this time, he began to explore whether the tools and techniques of business strategy could be applied to understanding the health and stability of countries. This research led him to the uncomfortable conclusion that many developed countries – including the US and the UK – are unwittingly pursuing economic policies which will result in the unwinding of 20th century civilisation before we reach the year 2050. Hearteningly, he also concluded that this fate is entirely avoidable. Mark is also the author of The Complete CEO (2) and The Zombie Economy (3). Mark is a Visiting Professor at IE Business School and has a degree in Mathematics from Cambridge University.

We launched *The Rational Policy-maker's Guide to the NHS* (4) the day before the 75th anniversary of the NHS last year, in the House of Commons.

We have also taken it to Holyrood and to the Senedd. Margaret Greenwood MP held a Westminster Hall debate (5) on the future of the NHS at which the report was discussed and today's presentation is based on a paper that we submitted to Lord Darzi, whose report seems to acknowledge a number of the points that we have made. So we have achieved a degree of traction and will continue to increase awareness and understanding of the modelling that lies at the heart of this report.

Imagine that you are a rational policy-maker and have been given the task of plotting the future course of the NHS. What would you do? You might ask yourself three questions:

1. What actually works in practice? There are about 200 countries in the world and most have health systems, but what works best?
2. The NHS is experiencing a lot of problems, but what is their root cause?
3. Is the NHS sustainable within our economy?

What actually works in practice?

We can try to benchmark the NHS's performance against other systems around the world, but this is actually quite complicated because of their diversity.

There are three things you can ask of a healthcare system:

1. You can ask it to be effective, providing good quality in the output it delivers.
2. You would like it to be efficient, delivering those outputs for a reasonable level of input, which in this case is money.
3. And you want it to be equitable in the care it delivers.

In addition, we care very much about outcomes, although these are not all within the gift of the health system, often being strongly influenced by factors beyond its control. The USA has the

lowest life expectancy in the OECD, but the main reasons do not lie within their poorly performing health system. The main reason is that so many people in the USA die before they reach the age of 45. They die early because of gun crime, drug overdoses and car accidents. Being in collision with an American car is much more dangerous than with most European cars. So context is important when looking at statistics.

We are interested in efficiency, but of course you have to put something in to get anything back from the system. If we look at the report from the Commonwealth Fund for 2013 (6), you would see that the UK ranks first for effectiveness, safe care, coordinated care, cost to the person receiving care and efficiency, and ranked second for equity. It only ranked tenth out of eleven for 'healthy lives', but as we have noted, that is not all within the gift of the healthcare system. So there is no question that, as a healthcare system, the NHS was very, very good not very long ago. The Commonwealth Fund produces a new report every 3 years or so and our ranking has certainly dropped, but over the long term the UK has had the best track record of any system, so the model on which it is founded is clearly proven. This is not wishful thinking or harking back to 1948. If you were a rational policy maker there is good evidence that the NHS model can work very well in practice.

So what has gone wrong?

The level of funding, the input to the NHS, is one of the obvious differences between the UK and other comparable countries (Figure 1).

The level of funding on UK healthcare (both NHS and privately funded) as a proportion of GDP is shown by the red line and is lower than in almost all comparable countries. We also have fewer hospital beds and fewer medical doctors per head of population. You can see the sharp kink in the curve – we had quite a rapid increase in funding until 2010, but there was then a change in government policy which was never declared, which resulted in a steady decline in spending as a proportion of GDP. You would get a similar picture if you were looking at spending in terms of dollars – we would be behind everywhere but Italy.

At the Westminster Hall debate, the government spokesperson said, "No. You're wrong. Let's kill this once and for all. The NHS is getting record amounts of money." In one sense that's correct. The top line shown in Figure 2 shows the nominal amount of money going into the NHS: if you ignore inflation; if you ignore population growth; if you ignore the ageing of the population structure; and if you ignore the impact of the increased prevalence of chronic disease. But if you are a rational policy-maker you aren't going to ignore those influences, because they are real.

The gap between the blue and orange line shows the huge decline in the value of the pound owing to inflation. Then the population has grown, so if you are looking at real spending per head of population, we are on the grey line. The population has also aged, which also has an effect, but a relatively small one, because, when you look at it in detail, the majority of health spending takes place in the final 2 years of life, and we only die once. But then there is another very big gap, which brings us to the red line, and that is due to the explosion of morbidity, which has not been completely explained, but much of it does seem to be related to the effect of poverty and stress. So the main factors at play are inflation and the increase in chronic ill health and, when these are taken into account, spending has failed to keep pace with need and we end up with a picture like Figure 3 (page 22).

This shows deteriorating outputs – numbers of patients waiting for diagnosis or treatment, and numbers of patients seen within 4 hours of attending accident and emergency departments. Outputs are the direct result of NHS performance relative to demand. Numbers on waiting lists had been falling rapidly until the global financial crash, but then started rising rapidly, long before the pandemic struck. Emergency patients seen within 4 hours had exceeded the target of 95% for 10 years, but began to fall increasingly rapidly after

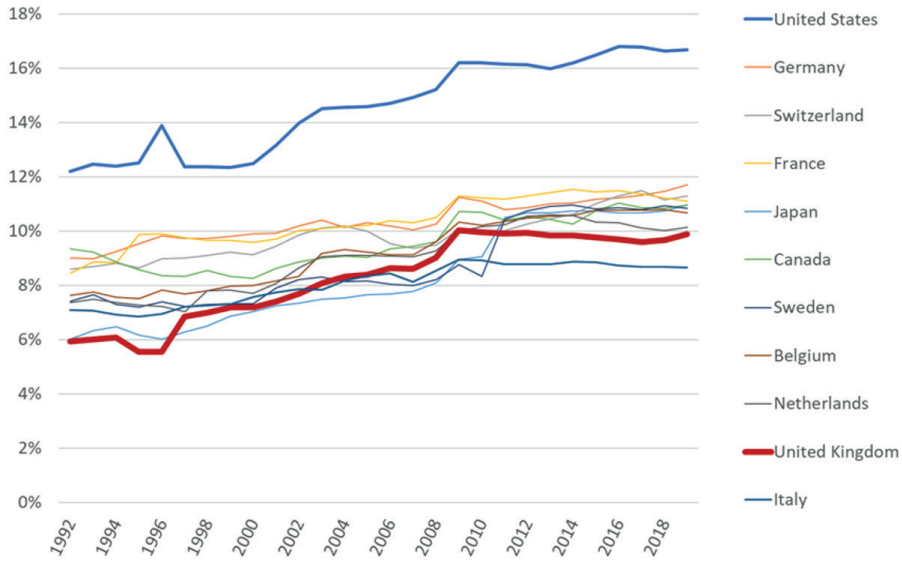


Figure 1 G10 total healthcare expenditure as a percentage of GDP. We spend less than most other high-income countries and our spend has been declining recently as a percentage of GDP. Source: OECD

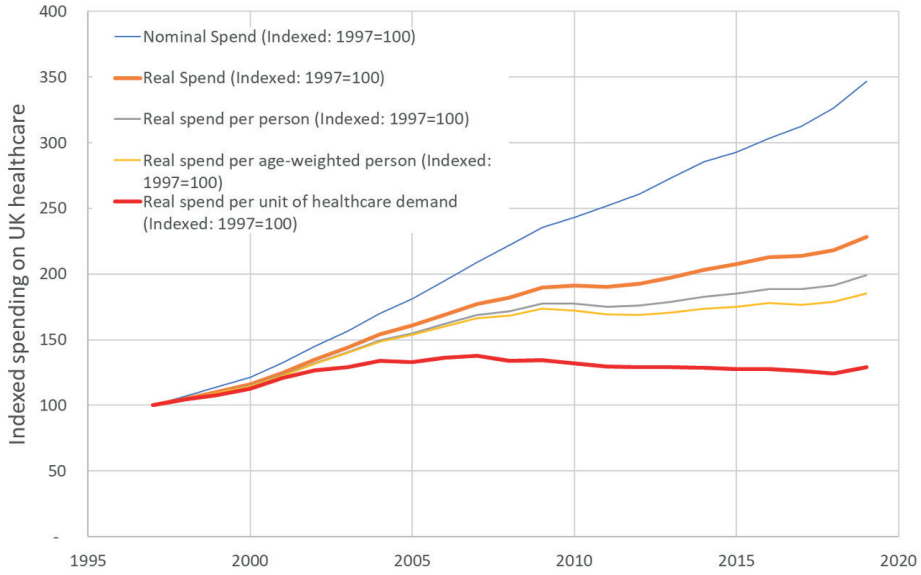


Figure 2 Healthcare expenditure is not enough to keep pace with the combination of inflation, population growth, ageing and increasing morbidity. Source: ONS, OBR, NHS Digital; 99% analysis

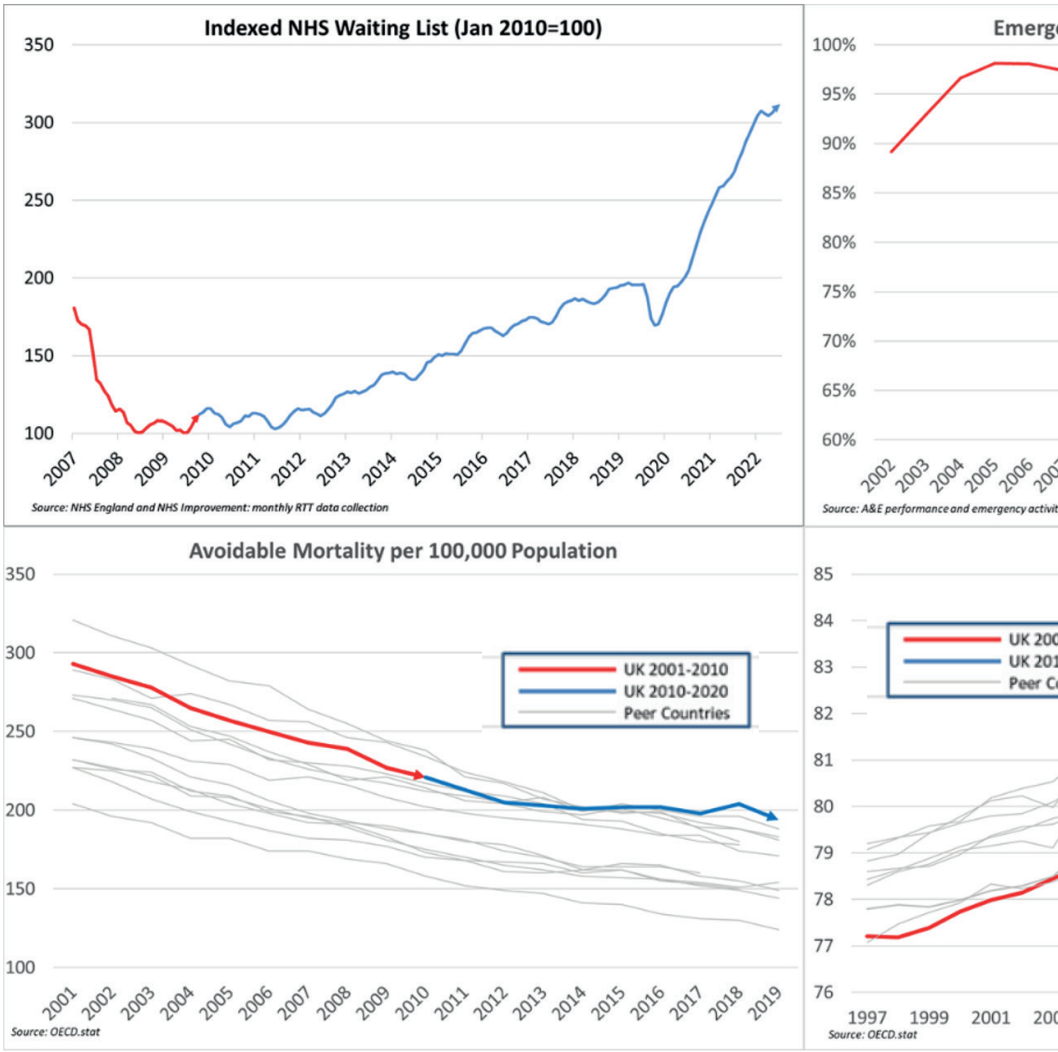
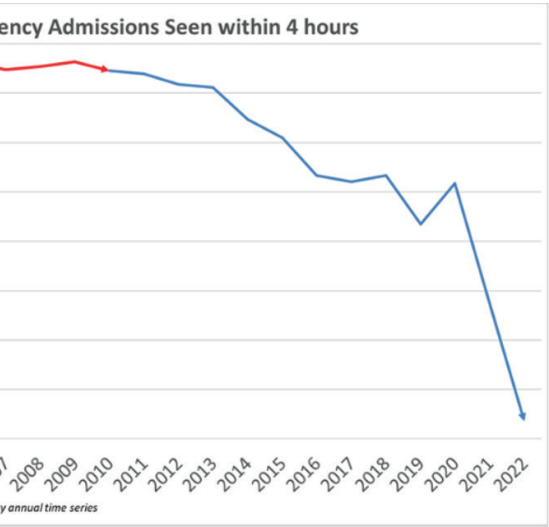


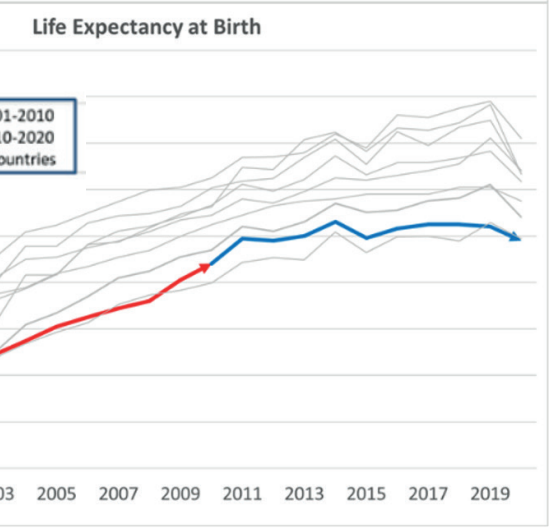
Figure 3 Declining healthcare performance levels and outcomes

2008 and plummeted after COVID struck.

Figure 3 also shows deteriorating outcomes – which reflect a combination of the results of the healthcare system performance and other factors outside the control of the healthcare system. It shows that avoidable mortality in the UK had been high compared with peer countries, but has increased to a greater extent since 2011 and a fall in life expectancy at birth in the UK and the USA, but hardly anywhere else.

So funding for the NHS has fallen behind historical norms, and behind peer countries, and





behind need. The result, unsurprisingly, is declining performance.

Is the NHS sustainable?

The third aspect we need to cover is the sustainability of the NHS in the context of the UK economy. Figure 4 (page 24) is rather strange for those unfamiliar with 'system dynamics', but it's simpler than it looks.

Each of the arrows represents a cause-and-effect relationship. Consider the red arrows: these refer to the performance of the economy – a capacity loop. The economy is driven by people, particularly by healthy people of working age. If there are more of them, the economy can perform better and if you have fewer of them, the economy will perform worse. If there are members of the population that require treatment, and you treat them successfully, the healthy population increases, but if you lack the capacity to treat them, the performance of the economy suffers. So capacity is vital, but if you don't fund it, you don't get the capacity, and if your economy is not performing well, you face plenty of arguments that we just can't afford to fund it any more. Therefore, this is a self-reinforcing cycle, which can either be a vicious cycle or a virtuous circle, depending on which way it is going. If you improve the health of the population, you improve the health of the economy, your budget constraints relax, so you have the capacity to treat more people – a virtuous circle.

Then we have the 'poverty loop', which reflects Sir Michael Marmot's work on the social determinants of health. A poorly performing economy usually leads to greater levels of deprivation. Deprivation affects people's lifestyles: their housing, diet, exercise and stress levels, affecting their health. And there is plenty of evidence that more people need treatment in a society that is very unequal, reducing the healthy population and further weakening the economy – a vicious cycle.

And then we have the 'prevention loop', in green. The WHO has calculated that every £1 spent on prevention of disease reduces the cost of treatment by £4, because you reduce the number of people falling ill. When you spend £1 on care, the general economy benefits by £4, so every £1 spent on prevention should benefit the overall economy by 4 x £4 – about £16.

So these are the elements we decided to model,

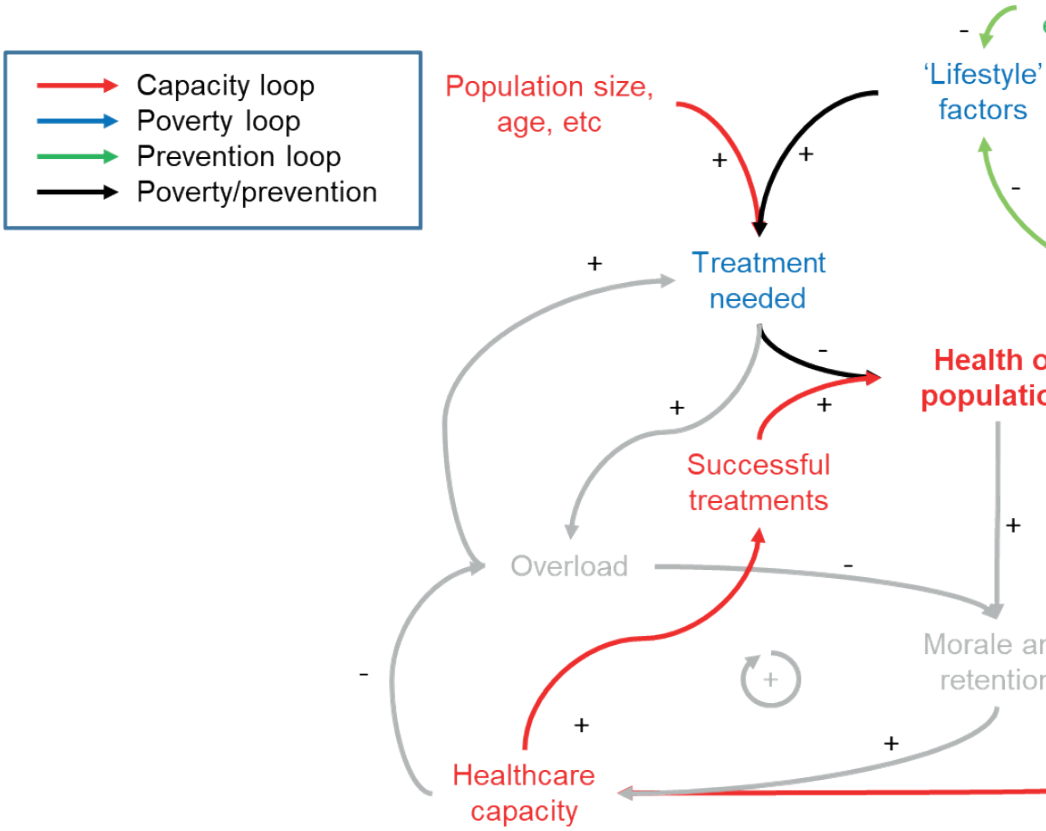


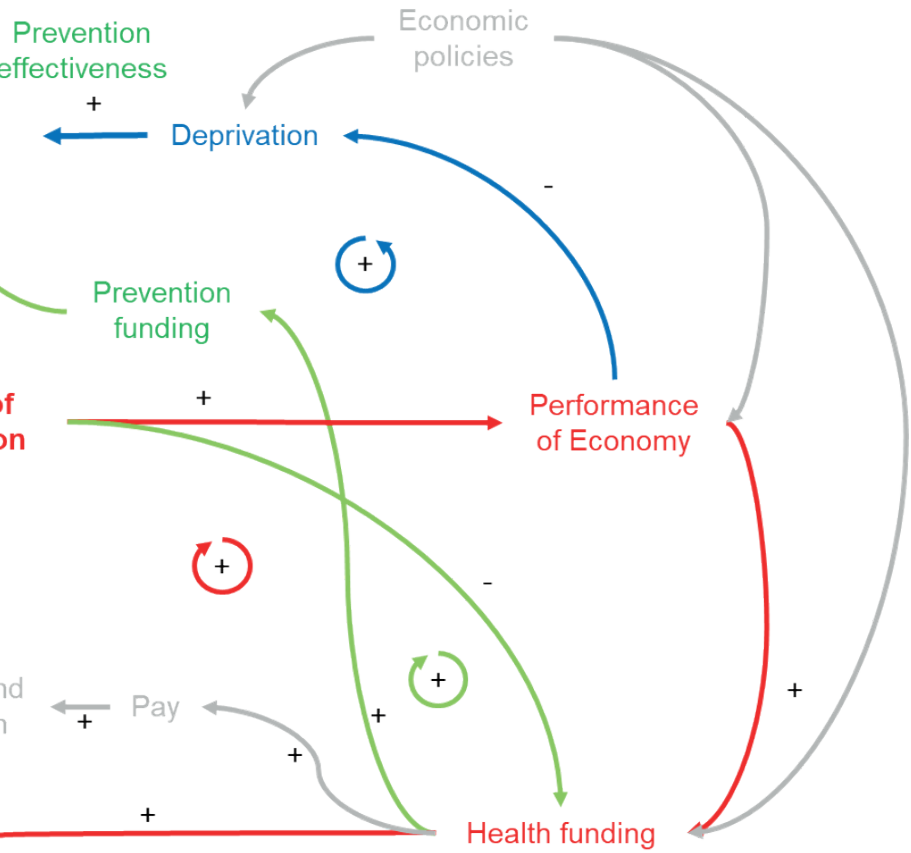
Figure 4 There are complex logical interrelationships between the healthcare system and the wider economy. Source:

to see if former Chancellor Sajid Javed had a point when he said, "We can't afford the NHS."

There is one element that we couldn't decide how to incorporate in the model, which related to the impact of an excessive demand on staff. If staff are overloaded, morale and retention are damaged, reducing capacity within the healthcare system and imposing an additional load on the staff that remain. Morale is damaged further by inadequate pay and conditions, and by the moral injury of seeing a deterioration in the health of the population you serve.

All of these self-reinforcing cycles interact with one another, so it is really quite a delicate and unstable system and, whichever rational policy-maker has their hands on the levers of power, they need to understand the delicacy of the system.

One reaction to a picture like this is to say, "That looks horrendously complicated: I'm just going to ignore it." But simply ignoring it doesn't change the real world, and the real world is telling us that these really are quite important concepts. The red line in Figure 5 (page 26) is the number of people of working age forced out of the workplace by ill



See pp.53-59 of The Rational Policy-maker's Guide to the NHS *(4) for an explanation of these system dynamics*

health and you can see those numbers shooting up until 1997, before gradually declining until about 2017, which was the last time that we had an NHS of world-class ranking. The numbers have been shooting up since then, and now include about 2.8 million people, about 8% of the workforce. A recent poll of UK business leaders showed that this is by far the number one issue they want the government to address.

A further illustration of the importance of a healthy population to the overall economy of the UK is shown in Figure 6 (page 28).

The grey line indicates the current GDP, at about £2.4 trillion, and the green line shows the OECD's prediction for the economy in 2060, at about £3.8 trillion. Based on their modelling, if we carried on at our current level of spending on healthcare we would fall a long way short of that predicted level of growth, but if we continued with the revealed government policy of continuing to drive down spending, the economy would collapse – potentially zero growth between now and 2060, which is practically unheard of in modern history. Of course, if a collapse were imminent, the

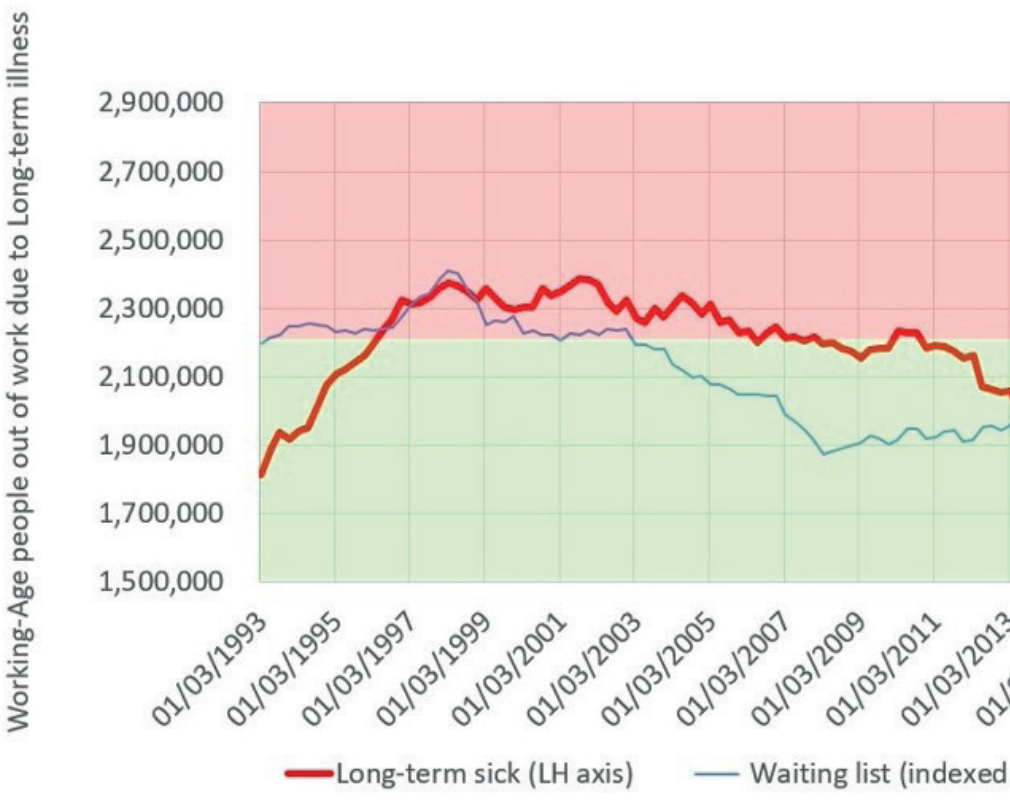


Figure 5 Working-age people out of work owing to long-term illness versus waiting lists. The NHS does not have a si spliced from two data sets and indexed. Source: NHS, ONS; 99% analysis

government would probably change course and try a different strategy, but the options might be very limited economically by that time.

What strategy options might we consider?

We might consider the radical step of funding the NHS properly. Or increasing spending on disease prevention. Or tackling both absolute and relative poverty. A policy that combined these elements might produce an expenditure curve like Figure 7 (page 29).

Under this policy, the level of funding increases rapidly over 5 years, to peak at about 14% of GDP, while you deal with the backlog of demand of about 8 million people currently sitting on waiting lists and becoming increasingly unwell, together with treating the natural demand of people who would be anticipated to fall ill during that period. So you would need to build up quite a bit of additional capacity until the backlog has been cleared, after which capacity requirements reduce, assisted by the reduced burden of disease anticipated through preventative health measures and poverty reduction policies. The pattern of

ingle data set covering waiting lists since 1993 so the line is

initial spending might look frightening to begin with, but it would in no way behave as Sajid Javed implied, that spending would spiral ever upward to consume almost the entire economic output of the country.

No gambling with the NHS

Our conclusion is that a rational policy-maker would recommit to the fundamental principles of the NHS and would not take an enormous gamble by switching to an unproven model.

It is conceivable that, at some time in the future, artificial intelligence might have reached a stage where some of the activities currently performed by highly trained doctors could be safely automated, but it is by no means certain that that time will come soon.

It is conceivable that a further reorganisation of the NHS might enhance its performance, but I have never in my life seen a reorganisation that made any great improvement. It would be a gamble and I do not think a rational policy-maker would take such a gamble when they had a proven model to hand. By all means do pilot studies, in limited areas of the service, but measure the impact carefully, over a sufficiently long period of time before deciding whether to roll out the changes more widely.

We practise evidence-based medicine: let's embrace evidence-based policy-making

We have shown that we do have a proven model, which was the best in the world until recently, so there is no need to look for an alternative:

The root cause of our current difficulties is underfunding.

The NHS is sustainable, if it is properly funded.

But if you don't fund it properly, the whole economy becomes unsustainable.

A rational policy-maker would:

- recommit to the fundamental business model of the NHS;
- fund it in line with need;
- invest in prevention;
- tackle the social determinants of ill-health.

The UK cannot afford an alternative strategy

While there are many operational improvements which can and should be made, they should be made within this strategic context and introduced with great care, given the strategic weakness and fragility of today's NHS.

We cannot afford to gamble with the NHS.

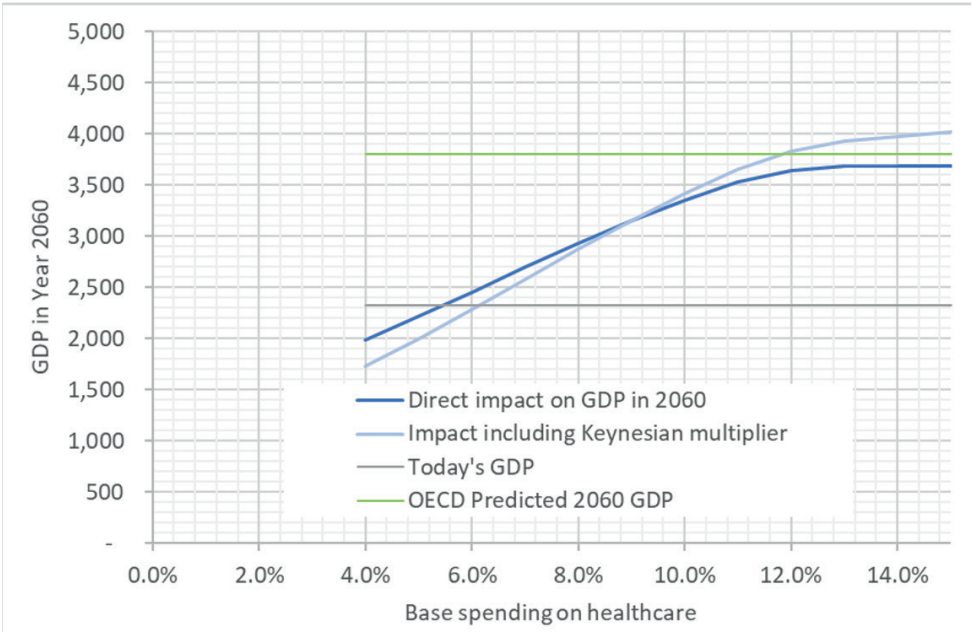


Figure 6 A policy of continued reduction of funding as a percentage of GDP is not sustainable. Source: 99% analysis

Read the report in full

The Rational Policy-maker's Guide to the NHS (4) is available to download, free of charge:
https://bit.ly/3CEGBRo.

The 99% Organisation's website also indicates ways to become involved in their work:
https://99-percent.org

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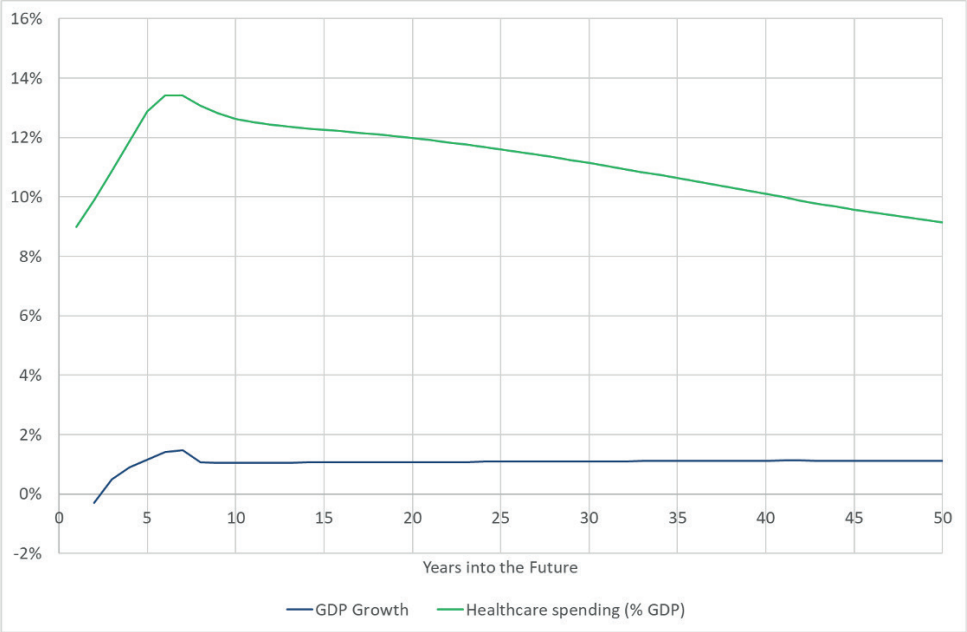

Figure 7 Adjusting NHS expenditure to meet demand would be sustainable into the long term.
Note: This scenario assumes: (1) that NHS spending is adjusted to meet need; (2) that there is increased spending on prevention; and (3) that there are effective poverty reduction policies in place which, over time, reduce socially determined morbidity. NHS spending is about three-quarters of total UK healthcare spend.
Source: 99% analysis

The Paul Noone Memorial Lecture 2024

Knowing when things are going wrong in healthcare. Why do organisations find it so hard to listen and act?

Professor Graham Martin
Director of Research, THIS Institute
Compiled by Colin Hutchinson

Graham Martin is Director of Research at THIS Institute, leading applied research programmes and contributing to the Institute's strategy and development.
Graham has a degree in Geography from Oxford University, an MSc in Society and Space from the University of Bristol, and a PhD in social policy from the University of Nottingham. He was previously Professor of Health Organisation and Policy at the University of Leicester, acting as Head of Department of Health Sciences from 2015 to 2018, and prior to that held research posts at Nottingham and Leicester.
Graham's research interests are in the organisation and delivery of healthcare, and particularly the role of professionals, managers and patients and the public in efforts at organisational change. Primarily a qualitative researcher, he has long experience of undertaking research and evaluation in relation to healthcare improvement, from major policy-driven programmes to locally led initiatives.

What is it about healthcare in particular, and bureaucratic organisations more broadly, that makes it difficult for them to do things with knowledge that is already present, not always unambiguous or necessarily clear, but does not reach the right people?

I'm going to talk to you about speaking up, and about informal sources of knowledge, as well as more formal sources such as national metrics, which form an important backdrop, but I'm going to talk mainly about the voice of staff, the act of speaking up and raising concerns; in extremes, the act of whistleblowing, although this has the particular connotation of going outside the organisation and tends to be a last resort, although it is important to have that option.

I'm going to focus less on what encourages people to speak up in the first place, because there is actually quite a lot of evidence about that and the NHS has been quite good at picking up that evidence, at least in terms of policy, communication and discourse: the term 'psychological safety' is well used and most people will have a good idea what it means. That is a vital part of getting organisations to hear concerns, but only the first part of what happens when people feel confident enough to raise them. I'm going to concentrate on what happens next. My talk will consist of three main parts:

1. Background – which will be sadly familiar to you.
2. What is going wrong and what makes it so difficult to fix.
3. What we can do about it, in our roles as clinician, researcher, manager, with the interests of the NHS at heart.

The background

The traditional starting point is the case of

the Mid-Staffordshire Hospital and the judicial inquiries led by Sir Robert Francis KC with all the issues that he found there, in terms of safety, the consequences for patients, including their dignity, the harm suffered and, too often, their death, but also what he had to say about the organisation and what allowed this to happen, and about the wider system.

One of Francis' most quotable passages was in the context of one patient who attended the emergency department after coming off his mountain bike, was inappropriately discharged, and sadly died a little later.

> **"For all the fine words printed and spoken about candour and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public scrutiny."**
>
> *– Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) (1)*

In making this observation, Robert Francis was looking particularly at the actions of the Trust's lawyers, who suggested that the coroner who was investigating this death was over-reaching, going beyond their brief, so that indicated the kind of conversations going on within the Trust. The senior A&E Consultants had prepared a report for the coroner which was very critical and, in the view of the Trust, was unnecessary and invited bad headlines. One way or another, the testimony of the Head of Emergency Medicine never reached the coroner, which Francis felt was likely a deliberate act of concealment. He recognised that this wasn't against the ethics of the solicitors, who believed they were acting in the Trust's best interests and protecting its reputation. They felt instinctively that this took precedence over disclosure of what really happened to the family and improving the quality of care through learning from mistakes.

Clearly, Francis was not speaking just to that particular event, in that particular institution, but to the wider system and its instincts. But, of course, Mid-Staffs is not Year Zero for this:

> **"An effective system needs to be introduced for the proper reporting of incidents that occur and complaints which are made at ward level."**
>
> *– Inquiry into Ely Hospital, Cardiff (1969)(2)*

These comments could just as easily have applied at Mid-Staffordshire. Similarly, from Ian Kennedy's report from the Bristol paediatric heart surgery review:

> **"The systems and culture in place were such as to make open discussion and review more difficult. Staff were not encouraged to share their problems or speak openly. Those who tried to raise concerns found it hard to have their voice heard."**
>
> *– Bristol Royal Infirmary Inquiry. Learning from Bristol. London: HMSO (2001)(3)*

The wording is very similar, so there is a history here and, of course, since the Mid-Staffs Inquiry, there has been the Kirkup Report into maternity services at Morecambe Bay (2015) (4); Robert Francis's review into *Freedom to Speak Up* (2015) (5), which made lots of recommendations; Gosport Hospital (2018) (6), which again raised the question of what was known and by whom, and the absence of oversight; and Scotland has not escaped, with the report into allegations of bullying and harassment in Highland Health Board (2019) (7); and Bill Kirkup again, in 2022 (10), into maternity services at East Kent Hospital, with a response from the Government, criticised as being very low key and left to junior Ministers to deliver. It is rather depressing the way that the responses to these inquiries have changed over time, becoming almost nihilistic; a sense that these occurrences are inevitable; certainly a loss of the sense of shock that accompanied Mid-Staffs.

But these problems are not unique to the NHS. They occur in other healthcare systems and other safety-critical industries. Tom Reader at the London School of Economics, who also researches

health systems, produced a very interesting piece on the Deepwater Horizon blowout (2010), which showed that there was prior knowledge of problems amongst those at the sharp end of the operation, the workers on the rig, who had tried to raise concerns, but which had somehow never produced a meaningful response from those higher up (8).

And we even find similar language in Sue Gray's report on the Downing Street parties taking place during Lockdown:

> **"Some staff wanted to raise concerns about behaviours they witnessed at work but at times felt unable to do so – no member of staff should feel unable to report or challenge poor conduct where they witness it. There should be easier ways for staff to raise such concerns informally, outside of the line management chain."**
>
> *– Findings of Second Permanent Secretary's investigation into alleged gatherings on government premises during Covid restrictions (2022) (9)*

Back in healthcare, East Kent did seem exceptional, certainly to Bill Kirkup: harm to mothers and babies over more than a decade; multiple opportunities to act – the signals were there; organisational dysfunction at multiple levels; ultimate responsibility lay with the Board; while other maternity services have been struggling, this appeared to be truly an extreme outlier.

> **"Accountability lies with the successive Trust Boards and the successive Chief Executives and Chairs. They had the information that there were serious failings, and they were in a position to act; but they ignored the warning signs and strenuously challenged repeated attempts to point out problems. This encouraged the belief that all was well, or at least near enough to be acceptable. They were wrong."**
>
> *– Kirkup 2022: 19(10)*

And this is a frequent finding in inquiries of this sort; enough signals to give them comfort and believe that all was well, or at least not exceptional, while ignoring the polyphony of warnings to the contrary. Kirkup identified seven big red flags from all sorts of sources, from parents and from within the Trust, but the Board failed to respond. Similar criticisms have been found at maternity services in Shrewsbury and Telford, and the neonatal unit at The Countess of Chester Hospital. This has occurred often enough that we cannot dismiss these as blips. There are also signals that other healthcare organisations are struggling. Illingworth et al., from Imperial College, set this in a global context that draws on a wide range of sources of data, including the NHS Staff Survey, the Friends and Family Test and Care Quality Commission inspections. From Mid-Staffs to 2020 there had been small but incremental improvements in the willingness of people to speak up in the NHS, in their confidence that they would not be punished for doing so, and their confidence that it would result in change. That improvement then plateaued in 2020, before declining, and hasn't really recovered (11).

This is also evident in sources such as the CQC's State of Care Report (12,13), which highlights the significant struggle that the NHS is facing in maintaining services in the context of the backlog in elective care, industrial disputes. Part of the solution to this must be a better funding settlement, but it also contributes to safety risks and a fear of speaking up. But there does also seems to be an increase in neglect and an erosion of compassion, particularly in mental health services, but also in maternity care, exacerbated by staff turnover, lack of training and low morale (14).

Why is it so difficult to know if things are going wrong?

So what can NHS organisations do about this? How do they tell where they sit relative to other similar organisations? There is no shortage of quantitative indicators of quality and safety, but

there is good evidence that their meaning and usefulness is not that great:

- Extreme outliers may be real but apparent differences between organisations 'in the middle' are often illusory
  – *Proudlove et al. 2019 (15)*
- Surveillance tools used by the CQC to inform risk-stratified inspection have weak predictive validity
  – *Griffiths et al. 2017 (16); Allen et al. 2020 (17)*
- Regulators and organisations alike may be dazzled by so many indicators
  – *Macrae 2014(18)*

With much of the data that is collected routinely, a slight alteration in the weighting applied to the data can make a radical difference to where an organisation is ranked within the hierarchy. Extreme outliers can be identified, but for most NHS organisations, the data don't tell us that much. Similarly, looking at the use of surveillance tools by the CQC to identify problems, or stratify inspections, the data don't actually correlate very well with the findings at inspection, so they are probably of limited value in telling us much about quality and patient safety, and the sheer number of indicators can be overwhelming (16,17).

Kirkup, in his East Kent report, referred to "a bewildering array of regulatory and supervisory bodies", which drew the attention of the Executive upwards, rather than looking downwards. They focused on relationship management and performance, rather than quality and safety.

So how can NHS organisations have confidence that they won't be the next East Kent or Mid-Staffs, or Shrewsbury & Telford? In an interview study that we did into changes in the NHS following Mid-Staffordshire (19), people would typically say things like, "We think we're ok, but actually they're not a very different trust from us." Or, "People tell me it couldn't happen here – I think it could happen anywhere." So there is a real sense of uncertainty, which is probably healthy in a lot of ways – complacency is the last thing you want – but it does point to the difficulty of knowing whether an organisation is doing well, or on the verge of collapsing.

If quantitative data has such limitations, what other sources of information can we use? The voice of staff correlates pretty well with other indicators and can give different insights. The long history of organisational research suggests that organisations (of all kinds) benefit from employee voice (eg Morrison 2011)(20).

In healthcare, there is a decent evidence base for associations between voice, quality and outcomes, between voice and patient safety and between voice and staff wellbeing (21,22).

Healthcare has been a productive setting for much organisational research on voice. There is a good evidence base for an association between people's willingness to speak up and other markers of quality of care. The term 'psychological safety' has entered NHS parlance and has been embraced. It comes from the work of Amy Edmondson, in the USA and includes the idea that, within a team, it is really important that you feel safe to raise ideas and concerns, feel able to question your colleagues regardless of hierarchy, and that you're not going to be disregarded, shut down, laughed at, or worse. There can't be many trusts that don't have psychological safety initiatives. It is valuable, but it focuses on the individual's voice, rather than what happens afterwards, and it's the property of the team, rather than of the whole organisation – so if the senior management of the organisation are still unwilling to hear those messages, it can be of limited benefit.

So, what else is important? This is, in part, about the nature of the matters people raise. We carried out an interview study looking at three hospitals overseas, asking what people actually did when concerns were brought to them (23). Some concerns are very straightforward, such as overcrowding in the emergency department; a machine that doesn't work; problems with a rota, a technical system or a pathway. But there are many other issues that can't easily be categorised

or objectified, such as concerns about a colleague or, "I'm not sure about this, but…." And these could either be reshaped, to try to make them fit into the categories of the system, or left unheard, even though they might be really important. Some things can be difficult to express. If a colleague you know well makes a mistake, you might think, "Is that just a one-off?" or, "Is it just my perception?" It is quite natural to have that kind of humility. If we raise the concern at all, we're likely to be very tentative, so this is the kind of information that is very easily lost – it doesn't fit easily into the boxes that the system is designed to record and process.

Similarly, after Mid-Staffs and Morecambe Bay led to Robert Francis' *Freedom To Speak Up* Review in 2015 (5), every trust was required to establish a Freedom To Speak Up Guardian (FTSUG); someone who, at least in theory, is there to help people find a way to speak up; raise its profile with the executive; and promote a culture of speaking up. But often the greater value can lie in the informal component of the role; maybe sitting down over a cup of tea with a staff member to discuss their concerns; exploring whether their concern is a legitimate one; whether it is a serious concern; what, if anything, they could do about it; and thinking through the options, with the risks and potential benefits of the different approaches. So much of the information is not easily categorised or codified, so without the FTSUG going beyond their formal role, potentially valuable information is at risk of being lost (24).

There are other ways to try and capture that information. The Institute for Healthcare Improvement in the USA has promoted patient safety walkarounds, in which the senior leadership team takes time to visit the sharp end of their institution, a ward, and emergency department, an operating department, to go and listen to the staff. It sounds like a great idea, but evidence from the UK and Canada shows that, when put into practice, the concept can get distorted into opportunities to check up on people, instead of embracing openness, listening to staff and asking how they can help.

The result is checklists and audits, talking to patients behind the back of staff, reproducing the logic of surveillance and upward accountability, too often resulting in a missed opportunity for the Board to learn, but also confirming to staff that this is all about performance. Too often it leads to the red carpet being rolled out, saying, "For this morning only, we are doing everything by the book." As Kirkup pointed out, it becomes part of relationship management – managing upwards, rather than managing downwards and confirming that this attitude runs through the organisation: that this is an appropriate way to behave (25,26).

Any organisation is going to have bits that are doing really well and other bits that are doing badly and, when we are talking about organisational culture, like Russell Mannion and Huw Davies made clear, we need to remember that any large organisation is not homogeneous when responding to these issues of quality and safety (27).

None of this is unique to healthcare. For example, a piece in the *Harvard Business Review* by Detert and Burriss makes the point that lots of initiatives to promote openness and speaking up can do just the opposite (28). When we try and put into practice measures to encourage openness and speaking up, it can have the opposite consequence, for example, open door policies – "Every Wednesday anyone can knock on my door and they can come in, and I'll listen to them."

The authors point out that, firstly, it puts all the onus on the employee to make that approach but, more importantly, it puts speaking up on a pedestal, something exceptional, because I'm making time for it as an executive. Rather, it should be normalised; a routine, everyday act. Likewise, anonymous suggestion boxes. Why should they need to be anonymised? They should be safe, routine, an everyday occurrence.

The other really important source of information is from patients. Even more than the voice of staff, the voice of patients is relegated to the sidelines, but there is very good evidence of its value. Gillespie and Reader, looking at complaints from patients, showed a strong correlation with

information from other sources and quantitative data, but too often organisations are unwilling to hear this (29).

What are the implications?

Going back to the piece from the *Harvard Business Review,* our approach needs to be much less about organisational initiatives like "Speak Up Friday" or formal management walkarounds. It's much more about local level activities, sensitively applied, making speaking up an unexceptional day-to-day activity. Senior leaders acting in isolation and viewing this as relationship management, or performance management, will fail. They need to bring the whole organisation along with them.

There are lots of ideas out there which are intended to reduce hierarchical relationships: psychological safety advice; reducing authority gradients; WHO surgical safety checklists: but not all of these are well evidenced and there is a risk of a pile-up of initiatives that can be overwhelming and lack focus and strategy. It is more important to intervene in the informal sense, encouraging people to speak up, especially if they don't feel able, and listening to what they are saying (30).

Going back to whistleblowing, which I am taking to refer to the Public Interest Disclosure Act (1998), and involves taking concerns outside the organisation: the NHS relies upon it, but it should be a last resort and should never have been necessary. If it gets to that stage, something has clearly gone wrong upstream.

The idea of 'chronic unease' comes from research on oil rigs, another safety critical industry. Chronic unease is not simply knowing that something could go wrong – everyone on an oil rig knows that – it's more about questioning whether our sources of information and how they are dealt with, are adequate, so that we can have an early indication if things are beginning to go wrong. This comes from research from Aberdeen University and is highly relevant to healthcare and shows that organisations that can embrace chronic unease can avoid the risks of complacency (31).

But don't expect this to be easy. Don't expect the pieces to fall into place readily. Rather, expect confusion, inconsistency, uncertainty as to the nature of the problem – if indeed there really is one. This is what all the literature tells us about the kinds of concerns that are raised, as we saw earlier on. It's also to be expected given the ambiguities and complexities of healthcare: rarely do problems present themselves unambiguously, with clear cause, clear culpability, and obvious solution.

But more than that – it's because people are parts of the organisations and microsystems they observe. And therefore they will very often be part of the problems they highlight – they may be implicated in them, they may have tangled relationships with those around them, they may be partially culpable for creating the issues they now see as becoming problematic. Because healthcare so often has to be delivered in suboptimal circumstances, people will very often have been 'complicit' in cutting corners and doing things in ways that aren't perfect, just to keep the system going. Henriksen and Dayton speak richly of the realities of being part of an imperfect system, with all the burdens and compromises that places on people, and their consequences (32).

So don't expect people to come to you with clear problems self-evidently deserving of action. Don't expect people to sort themselves out neatly into culprits and whistleblowers, sinners and saints. And don't expect people to be clear, reasonable and rational: indeed it may be their obstinacy, their unreasonableness and their courage that makes them come forward.

As someone listening to concerns, you cannot expect to get a clear and unambiguous warrant for action. At best you are going to hear something that suggests there might be a problem that requires further investigation.

What next?

There is a lot that we still need to understand:

- We need to evaluate better the impact of

existing initiatives, including their long-term impact (33).

- We need to be more aware of initiatives from other sectors in characterising, piloting and evaluating safety and quality in those fields and how they might be applicable to healthcare.
- We need to consider the specific requirements of particular parts of the service: ambulance trusts, for example, tend to have a weak staff voice and to be more hierarchical than a lot of other parts of the NHS.
- We need to find a way to reconcile the disciplinary and other human resource management processes so they do not act as a deterrent to speaking up.
- How does implicit bias affect the way that people speak up and their willingness to do so, or suffer adverse consequences, in terms of ethnicity, sex, professional background?
- We need to learn more about the organisational response to concerns and the processes they put in place, so the right information gets through to the right people and elicits the appropriate action.

So that is my next 20 years' work in a nutshell!

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CHPI | Centre for Health and the Public Interest

The Centre for Health and the Public Interest (CHPI) is an independent research thinktank which is focused on promoting the public interest in health and social care.

They look in detail about issues relating to the use of the private sector to deliver NHS and social care services and use robust authoritative data to help in their mission to promote the founding principles of the NHS.

Over the course of the last year they have produced a number of reports and articles looking at what has happened to NHS eye care services which have been outsourced. [*DFNHS collaborated with this.*]

Working with colleagues in the ophthalmology profession they produced research showing the very large growth in the number of NHS funded cataract operations which were being delivered by the private sector and how this had driven high levels of expenditure on cataract services, at the expense of other more serious sight-threatening conditions.

In addition, they demonstrated that this policy had led to NHS eye care departments losing income and staffing which both hampered their ability to treat more complex patients as well as limiting their ability to train new consultants.

This research was covered on BBC Newsnight, in the *Guardian* and the *Observer* and CHPI discussed it at their two public events in Manchester and Birmingham where they engaged members of the local community in a discussion about the growth of a two-tier healthcare system and what it means for the future of the NHS.

They have also been involved with the COVID 19 public Inquiry as a core participant, providing detailed evidence to the Inquiry on the use of the private hospital sector to support the NHS.

As they have shown previously how the government spent over £2 billion during the first year of the pandemic to use the private hospital sector, but relatively few NHS patients were treated in private facilities.

Their earlier research into this issue also showed that the government and the leadership of NHS England struck a contract with the private hospital sector which actually encouraged the sector to treat more fee paying patients, potentially at the expense of NHS patients.

In their submission to the Inquiry CHPI pointed out that had the private sector been required to focus solely on NHS patients rather than fee paying private patients, then around 1 million additional NHS patients could have been treated.

Heading into 2025 they will continue to work on the outsourcing of NHS eyecare services and they are also due to publish an online map of all the profits which leak out of the NHS as a result of the growing use of the private sector based around each of the 42 Integrated Care Boards.

DFNHS will continue to liaise with CHPI in 2025.

Contact: https://chpi.org.uk

EXECUTIVE COMMITTEE : Elected at AGM 2024

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

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