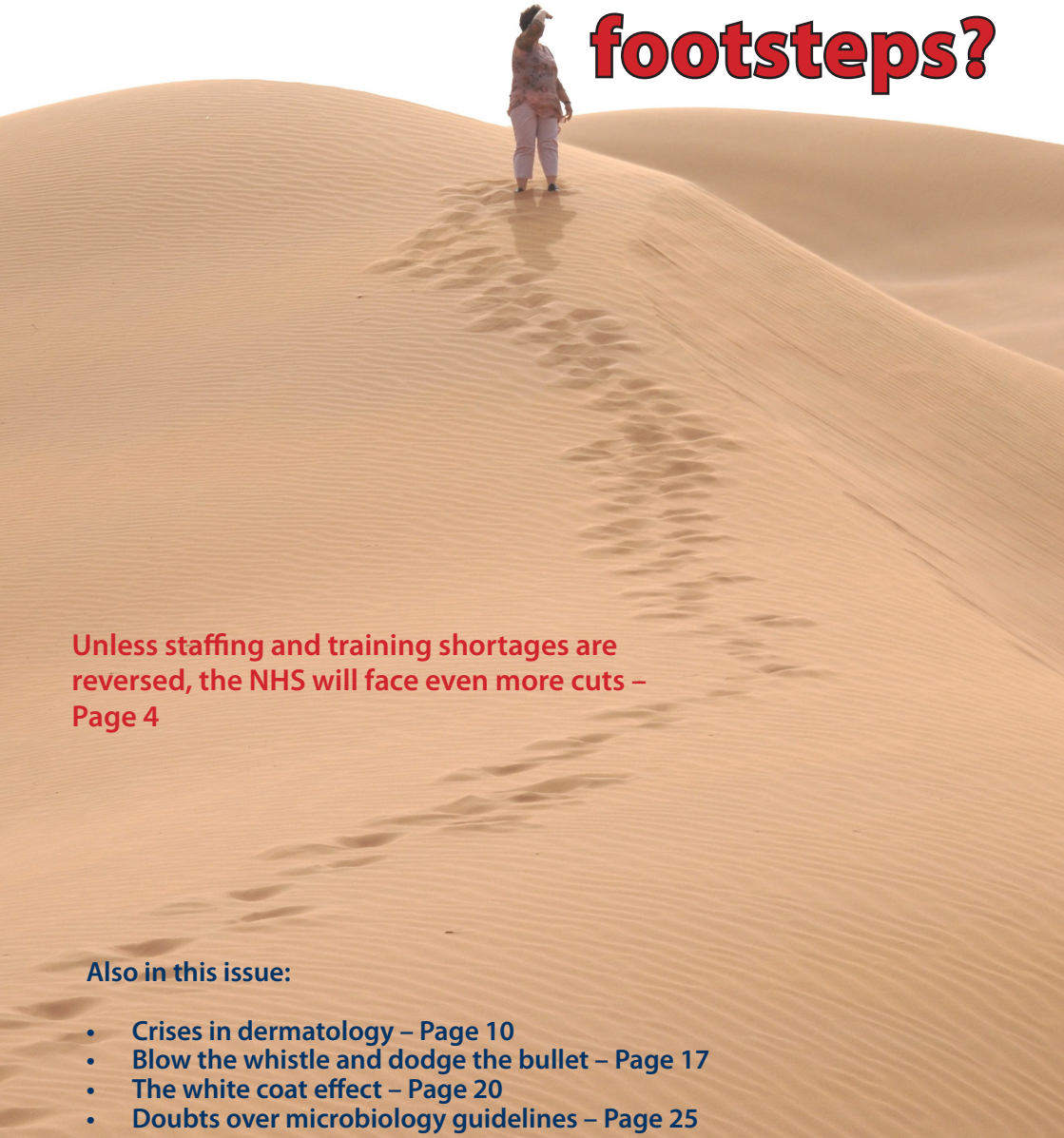
DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

Deserted footsteps?



Unless staffing and training shortages are reversed, the NHS will face even more cuts – Page 4

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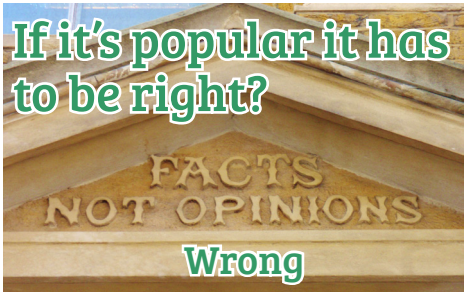

The English have never much liked directives from the Continent. We are European (when it suits us) but not Continental.

In the early years of the 15th century there was a general disaffection about edicts emerging from Rome and that disapproval led on to the Reformation. We were not in the front rank but we were there, though partly for reasons of our (or at least Henry VIII's), own.

500 years later much the same story emerges. We do not like directives telling us how to live our lives, coming from European (Continental) bodies, any more now than previously. This time we are in the lead, but others could follow. In 15th century the European authorities in question did little or nothing by way of self-examination. This time there are conflicting messages. On the one hand we hear "we must make exit difficult to discourage others from thinking about leaving" but perhaps more encouraging we also hear "we must reform our ways, this must be the stimulus" – even if we never quite get round to it.

The Brits, or at least the English, came to their decision after a campaign which was nothing short of a disgrace. A partisan press giving "authoritative opinions", lies and counter lies, the Brexit bus promising £350 million a week for the NHS – a promise dropped within an hour of the result, a government minister (Gove) advising that "people in this country have had enough of experts" [1] (ironically followed by the new leadership demonstrating that they had had enough of Gove). Surely what was needed was authoritative, expert advice on the consequences of both Brexit and Bremain, to listen to wise comment and then to decide? We came nowhere near to any of this. The Tay Bridge fell down in 1879. Opinion at the time was that cast iron would be all right. It was not, it failed. There had been no testing of the relatively new use of this material in this setting. At least this disaster resulted in the setting up of David Kirkaldy's Testing Works in Southwark (south London) which has "Facts not Opinions" in large letters over the entrance. It is still there. Mr Gove (and others) could usefully go and look. He probably has more spare time recently.

Some evidence-based health policy would be a very welcome change, and the now reintroduced NHS Reinstatement Bill, scheduled for a second reading on 4th November, could give Jeremy Hunt another chance to look at the well-documented facts about the huge and wasteful management costs of the healthcare market, the many disadvantages of private providers, at PFI....

Mr Hunt could also look at funding, currently the lowest in the OECD as a percentage of GDP (and falling further still), with fewer doctors, nurses or hospital beds here than almost anywhere else in Europe. 93% of the UK population in a recent Social Attitudes survey think there is a funding problem so when stating that in his opinion "the NHS has the money it needs", he is in a small minority.

Will he look at the facts and the evidence? Somehow it doesn't seem likely.

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Where are our future staff?

'No nurses, no NHS' appeared on hundreds of placards around England and Wales at 'Bursary or Bust' protests. Likewise for doctors, yet the situation for both is critical.

The NHS cannot function without staff. A recent Health Foundation report, *Staffing Matters, Funding Counts* [1] states that the main barriers to achieving a long-term vision for the NHS in England "have been the results of national policy changes focussed on saving money without fully considering the workforce implications".

In 2010 there were 25,904 nursing degree places in the UK. To save money, this number was cut by 13.6% to 21, 529. The biggest drop in nurse training places was in London where 16% of places were lost. What a coincidence that there has been a 50% increase in nurse vacancies in England and Wales between 2013 and 2015 (12,513 up to 18,714) with 93% of trusts describing nurse shortages. Nursing degrees are very popular, with 54,000 applications last year. The proposed loss of bursaries for nurses and allied health professionals in England and Wales caused massive protests but was quietly confirmed before the parliamentary recess in July. Economists have predicted a 6% drop in student numbers, particularly among mature students. The government claims that the loss of bursaries will result in 10,000 more training places by the end of this parliament, but universities do not share this optimistic forecast and expect their overall income from healthcare students to reduce from £851 million to £795 million in the next year. This report predicts a loss of 2100 students a year, resulting in costs of £100 million a year for agency staff.

Midwives are also in short supply. *The State of Maternity Services Report* [2] describes a lack of 2600 midwives in England and Wales, with staff shortages in nearly 30% of units and over 40% of units had to close to admissions at some point. Many nurses are nearing retirement; in 2014 7500 (2.4%) retired, but many more (17,800) left before retirement age. Some will have been offered 'MARS' schemes as at my own trust, as a short-term fix to save money and will not be replaced, but this worsens current staff shortages. The Francis Report revealed problems caused by a long term lack of nursing staff. An RCN report *Guidance on Safe Staffing Levels in the UK* [3] shows that patient care is regularly compromised if wards have 8 or more patients per registered nurse, and often this is not nearly enough. If there are more health care assistants than nurses patient mortality rises by 10%. Inadequate staffing causes stress and unhappiness among nurses and results in increased sick leave and loss of morale. Following the Francis Report, many trusts have tried to recruit more staff but nearly 90% of acute trusts are now in deficit.

How about doctors?

As well as cutting nursing places, medical school places have been cut from 6195 in 2012 to 6071 now, even though government figures in 2012 estimated a need for 27,000 more doctors by 2025. *Staffing Matters* shows a 60% increase in vacant medical posts (2907 to 4669) between 2013 and 2015 [1: 6]. This will be an underestimate as trusts may not advertise in the absence of likely applicants. 36% of all current NHS doctors were born overseas and many of the 13,000 doctors who register with the GMC each year were trained in countries which cannot afford to lose them. 10% of registered doctors (and 4% of nurses) are now from the EU and the effect of Brexit is as yet unknown. Restrictions on immigration from non-EU countries have already affected recruitment.

61% of doctors under 30 are now female and many have career breaks or work part-time. This has not yet been adequately allowed for.

A recent RCP report [3] shows that about 40% of advertised consultant posts are unfilled because of lack of suitable applicants, worse in some specialties than others. 20% of emergency

medicine posts are currently vacant. Dermatology is one of many shortage specialties and all my local trusts have locums or unfilled vacancies. Some specialties are unpopular with trainees, but for others such as Dermatology there is immense competition for the few SpR posts. Funding for Health Education England has been cut and HEE refuses to fund increased numbers of trainees as it is "not a priority".

The use of agency locums often increases stress on substantive staff and it is worrying, though not entirely surprising, that some trainees may choose this lucrative work rather than a commitment to a permanent post. It has been calculated that a trust could employ four substantive consultants for the cost of one agency locum, with great benefits to the service. Revalidation, soon to be imposed on nurses too, takes up a lot of time and apparently [4] costs over £97 million a year while only preventing 0.75% of instances of death or moderate or serious harm. Retired doctors may be unable to work as locums if they have been unable to keep up with appraisals.

Consultant vacancies affect training. Units without two consultants on the Specialist Register cannot train an SpR so precious training places may be lost as has already happened in my region and may yet occur at my trust. Vacant posts may make it impossible to sustain a unit and the whole service may be lost to a much less satisfactory private sector provider.

We all know of problems with GP recruitment. Even HEE's GP taskforce in 2014 concluded that 'there is a GP workforce crisis in certain areas' [4] but this is now widespread. In some areas only 60-70% of GP training places are filled, while applications have fallen by 15% in a year. A 2015 Civitas report [4] said 20% of GP posts were vacant, with many GPs nearing retirement and 1 in 3 retiring early. 'Moving care closer to home' [5] gives far more work to GPs but without staff or funding and consultations have risen by 15% in 5 years.

Outsourcing to private providers harms training. If common conditions are removed from consultant clinics, students and trainees will not see them, while the private-sector service is unlikely to be willing and will all too often be unsuitable to train. A survey early last year showed 70% of young doctors were considering emigration, locum work or even giving up medicine completely. We have to look after junior colleagues; they need to feel a valued part of a team and enjoy their work as well as having some time for family life. All too often they do not.

We already have far fewer doctors and nurses per head of population than most developed countries. For the whole NHS, the staffing situation is both serious and urgent. Proper funding and better planning are needed. 'New ways of working' cannot solve this.

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Congratulations

Two DFNHS members have achieved notable success since the last issue of the newsletter.

David Wrigley, Lancashire GP and EC member, has been elected BMA Deputy Chair. "I am certainly keen to make a difference in the role and for the BMA to reach out to members and non-members", he said. "I will also be looking to highlight further the ongoing destruction of the NHS.

"Cuts and closures are decimating services and patients are the ones who will suffer immensely. Doctors have a huge role to play in highlighting these issues."

David has worked tirelessly for years to uphold the aims of DFNHS and is the co-author of *NHS For Sale*. (Available from KONP, £12 with bulk-buy discount: http://keepournhspublic.com/shop/books/nhs-for-sale-myths-lies-and-deception/)

Raymond Tallis has been elected to the Council of the Royal College of Physicians, London. An authoritative voice on health policy, philosophy and the NHS, Ray told us: "My intention is to use my role as Councillor to press the college to take a more robust stand on matters political." Welcome pressure indeed!

Rays' latest book, *The Mystery of Being Human: God, Freedom and the NHS* (out this month), includes a critical account of the deception intended to destroy the NHS, and the values that have created and sustained it. (See review on page 31.)

EWTD: Is Br

Mark Aitken's ***Opinion*** piece on our website was openly challenging about the assumptions underpinning application of the EWTD to doctors' working hours (http://www.doctorsforthenhs.org.uk/news/ewtd-idea-whose-time-gone/) and sparked an interesting exchange of views, some of which were also uploaded (http://www.doctorsforthenhs.org.uk/news/ewtd-comments/). Here, DFHNS President Peter Fisher offers his own perspective.

The European Working Time Directive has been a very important piece of legislation for people in many occupations, particularly those which involve physical labour. It was not, however, designed with healthcare in mind and has caused problems in that area including for those who are trainees.

Other European countries were widely suspected of applying the rules more flexibly in their healthcare systems than was the case here in the UK but this was never properly investigated.

The really devastating factor was that of the SiMAP and Jaeger judgments [1] which ruled that any time spent on hospital premises if resting, or even asleep, counted fully as work to be deducted from the maximum 48 hours per week.

This made it very difficult to staff the smaller District General Hospitals, as the lesser workload meant that junior doctors, with the limited hours, had too little opportunity for patient contact and the posts lost training recognition.

In an attempt to deal with this, the concept of "on-call" was replaced by shifts but being on duty for an out-of-hours shift in a relatively quiet hospital presented the same problem of inadequate patient contact and training opportunities.

The change to shifts rather than "on-call" was also instrumental in the demise of the traditional "firm" system and the consequent

rexit time for a change?

loss of continuity of care has not been good for patients, junior doctors or their consultant colleagues and may have played some part in the current loss of morale and job satisfaction.

Could Brexit provide an opportunity for a re-examination? It is hardly an ideal moment to be looking at further changes in Junior Doctors' working conditions, but time is not on our side. Closure of beds and whole services in DGHs is going on apace, driven by underfunding, transformation programmes based on unrealistic assumptions of how much can be achieved with enhanced community care, and the difficulty of providing staff, particularly at middle grade.

In the past I believe there was a system for grading posts, with remuneration for out-of-hours work based on how busy the unit was and how likely the doctor "on call " was to be disturbed.

Would it be possible to apply the same principle to calculate how many hours of work an on-call period should represent? Such a proposal would need to be introduced sensitively, perhaps with volunteers in one or two pilot areas.

I should declare an interest, being retired after 28 very enjoyable years as a consultant in a District General Hospital and now an active member of the campaign to maintain its core services.

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Moving safely

Many workers were affected by the EWTD. The group most commonly associated with regulated hours are professional drivers and pilots. But the situation for them is hardly a clear road either.

If you are driving a heavy goods vehicle or passenger vehicle in Europe or the UK:

"A driver must take a daily rest period within each period of 24 hours after the end of the previous daily or weekly rest period. An 11 hour (or more) daily rest is called a regular daily rest period."

(UK government guidance: see https://www.gov.uk/guidance/drivers-hours-goods-vehicles/1-eu-and-aetr-rules-on-drivers-hours)

If you are driving a train in the UK, the working hours and rest periods are tightly defined, though flexible up to recognised maximums. See http://www.aslef.org.uk/files/134490/FileName/ASLEFRosteringLflt.pdf

Finally, the UK regulations regarding sleep and working hours are (understandably) more tightly defined by the Civil Aviation Working Time Regulations (CAWTR) for pilots and others, and other legislation imposes responsibilities on aviation employers and employees to interpret and uphold them correctly. See http://www.hse.gov.uk/aboutus/meetings/hscarchive/2003/160903/c133b.pdf for the "basic" framework.

NHS on Life Support

The state of play and what's to be done about it – in a nutshell

I want to give a broad political overview of what's happening in the NHS in England and of the background to the current situation.

I'm a public health doctor, recently retired from the University of Liverpool where I've had a 20 year career in academic public health. Before that I worked for 20 years in NHS public health in Liverpool. Although my particular interests are in health inequalities, for the last 15 years or so – since Blair's Labour government started privatising the NHS – I have been an active NHS campaigner. In 2005 I was a co-founder of Keep Our NHS Public. I've been a member of NHSCA/DFNHS and of the Labour Party for over 35 years, and of MPU/Doctors in Unite for 30 years.

As you'll know, the English NHS is in a bad way, with practically every part of the country in financial deficit. Many hospitals and many services are being closed down, cut back or rationed. At the same time, many long-term contracts for the provision of NHS services are being awarded to private sector companies - though often people are unaware of this because the likes of Virgin, Carillion and SpecSavers are allowed to operate under the NHS logo.

By definition, these arrangements are wasteful, because private companies have a duty to make profits and to give those profits to their shareholders. That means that public money is haemorrhaging out of the NHS - whereas when a public provider of NHS services makes a surplus it is reinvested in the NHS.

There is also a substantial legacy of (mainly Labour initiated) private finance initiative (PFI) funded hospitals, whose exorbitant loan interest payments have to be made before NHS funds can be spent on routine services.

And it's no coincidence that people's inboxes are filling up with adverts for health insurance, with their invitations to jump the NHS queues. Everything I've described forms part of what in my view is an intentional strategy by the Conservative government to create financial, managerial, professional and public chaos throughout the NHS, so that private provision of NHS services, alternative private health services, health insurance, and NHS co-payments and ultimately charges will be seen as inevitable.

This 'cultural revolution' takes many different and apparently unrelated forms whose destructive nature is denied by the government – which continues to assert that it has the public interest at heart and that it is factors like the ongoing impact of the credit crash, the increasing costs of drugs and medical equipment, the ageing population and our unhealthy lifestyles which are the true problems facing the NHS.

The building blocks for privatisation to which I have referred currently include:

- The aforementioned awarding of NHS contracts to private bidders – often asset strippers who provide poor quality services, fragment and undermine the cohesive public ethos of the NHS.
- The creation by the Treasury of NHS deficits and of regulations which forbid them. Enforced rationing of services to extend waiting lists and encourage patients to seek private alternatives.
- Manufactured confrontations with

doctors and other members of the NHS workforce. The imposition of 'new models of care' which undermine NHS hospitals and create community based healthcare structures ripe for privatisation.

- Personal health budgets, designed to link with health insurance.

There are many more and I can provide documented evidence for all of them. It is a national scandal.

I'm not usually a conspiracy theorist; the reasons I feel confident in making these claims are because my and other people's researches over the last decade have revealed a series of papers and reports going back to the 1970s, in which the eventual privatisation of the NHS is laid out. Their sources include the Conservative Research Department, the Central Policy Review Staff, the Adam Smith Institute, the Centre for Policy Studies, and various leaked media reports of speeches by politicians and privateers.

A few names occur recurrently – most notably Oliver Letwin, who helped plan many of Thatcher's privatisations of public goods and services and who until July this year was a senior minister in the government. It was Letwin, not Secretary of State Andrew Lansley, who ensured that the Health and Social Care Act 2012 passed into law. The monumental 350 page HSCA – drafted by corporate lawyers – constitutes the complete enabling legislation for full privatisation of the English NHS.

What is to be done? Until we have a government committed to tackling and reversing this appalling onslaught on our beloved NHS, we must continue to expose what is happening, to challenge it and to campaign loudly and widely in order to increase public awareness and action. Even in opposition we can draft legislation and campaign around it: the NHS Bill, first tabled in the previous parliament as a cross-party bill by Green MP Caroline Lucas, with support from Jeremy Corbyn and John McDonnell, was reintroduced as a Ten Minute Rule bill by Margaret Greenwood MP on July 13; it will have its second reading on November 4. Drafted by Professor Allyson Pollock and barrister Peter Roderick, it would reintroduce the Secretary of State's duty - abolished by the HSCA – to provide a universal, nationalised NHS in England. We must continue to do everything in our power to sustain a Labour Party which supports these aims and to defeat the neoliberal policies that are destroying our NHS.

Websites

www.KeepOurNHSPublic.com
www.HealthCampaignsTogether.com

Further reading

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Skin Deep: the Dire Trends Undermining Dermatology

With 296 UK trusts, in a state of flux because of mergers, the clinical service unit of the British Association of Dermatologists is kept busy reviewing tenders, contracts and service specifications along with challenges to commissioners.

Contracts/Coding

Working for providers, contract managers negotiate contracts, often with inaccurate coding and little engagement with clinicians and patients. The margin of error for NHS tariffs ranges from:

- £69 and £93 for a follow-up, adult and child respectively.
- £106 for an adult, £129 for a child seen as a new patient.
- Procedures coded from cryotherapy (head and neck) £107, phototherapy £115, excision lesion skin £123, and dermoscopy at £134.

Hence small coding errors, when magnified by the volume of dermatology patients seen (716,8302 new GP referrals per year), can result in good quality dermatology units being driven to extinction.

Income pressures, usually due to inaccurate coding, may trigger a whole train of events, including leverage from the secondary care trust management to close dermatology units. This allows the ever present private provider to win tenders for community provision, as has happened in swathes of the country.

History has taught us that no one is immune from closure, not even well established academic and training units in teaching hospitals [1]. A piece from , the BAD president, in the September 2015 newsletter highlighted the pressures leading to the deterioration in the Nottingham dermatology unit [2].

Changing disease epidemiology leading to pressures

Over the 5 years from 2007/8, there was a 15.5% increase in GP referrals for dermatology [3], with a 133% increase in basal cell carcinoma in 20 years, and a 50 % in melanoma in 13 years. Skin cancer incidence has rocketed to 14,000 melanomas and 300,000 non-melanoma skin cancers each year [4].

Dermatology workforce: consultant employment options

What is currently the most attractive option? Fully qualified UK trained consultant dermatologists are a dwindling luxury, relative to the increasing demands and expectations of an increasingly affluent and ageing population.

Despite the Royal College of Physicians recommendation of 989 whole time equivalent (WTE) consultants for our 61.8 million population [5], in 2012, there were 729 consultant posts,72.6 WTE vacancies and 70.9 WTE locums. In 2014, at least 74 locums were not on any specialist register, with 3 locums on the register for a completely different specialty to dermatology [6]. In 2014/15, Health Education England reduced dermatology training numbers to 177 from 178 [7].

On the background of rapidly rising demands, with a limited resource, even committed vocationalists are forced to consider all options in a field where commissioning is often driven

by short-term tactical decisions designed to minimise price paid, rather than to improve value for patients. Service fragmentation and false economies threaten quality of care.

Traditional full-time substantive NHS post

Options for working, once in receipt of a certificate of completion of training, include full-time NHS practice (salary on maximum of scale £101,000 pa and falling with a proposed new consultant contract, paid annual and sick leave, an NHS contributory pension with medical defence paid as crown indemnity).

Locum working for an agency

A full-time agency locum in the NHS historically earned on average £210,000 pa. This is double their NHS counterparts, without any of the hassle/ fun/ responsibility (depending on your outlook), but without benefits, before the recent government mandated locum salary cap. The word on the ground suggests that this has caused the locum tap to be turned off, resulting in further enormous pressures for trusts, trying to avoid punitive fines from breaching waiting time targets.

Traditional private practice

The mean private sector dermatology income in 2014 was £121,000 pa, with annual expenses of £38,000 and profit of £83 000 [8].

However there is real deflation in private sector profits, with a 60% rise in the last year in defence subscriptions, falling reimbursements (BUPA reimbursement for "excision lesion skin trunk under local anaesthetic" in 1995 was £146.25 but is now £107 (20 years later) rather than £253.61, allowing for inflation averaged at 2.8% per year [9]).

Previously fringe/grey

Now attempting to become mainstream area of private providers seeing NHS patients:

(a) Model of fee for service, using standard NHS tariffs

In dermatology, there is the option of seeing NHS patients in the private sector via choose and book referrals. This is now commonplace in orthopaedics, with some private hospitals, gaining a third of their income from NHS patients. In dermatology, average reimbursement for five clinics per week over 44 weeks would equate to £105, 000. This is the same pay as a substantive consultant but the equivalent of working mornings only, without any responsibility for running a department, looking after inpatients, teaching or training medical students, doctors and nurses. However, like a locum, this would be without benefits. Training the current and future dermatology workforce is essential for future adequate dermatology care.

(b) Private consortia bidding for 3-5 year contracts for community level dermatology

Similar pay is being offered by private community outpatient providers, employing consultant dermatologists. For those entrepreneurial dermatologists, setting up and leading their own community models, who is to say exactly what possibilities await? Community dermatology groups are multiplying and include private local general practice consortia, private UK and foreign companies diversifying into healthcare and business minded NHS consultants, leaving the salaried sector and developing consultant led but nurse and "specialist" doctor (credentials often unclear) delivered community practices. Many are on multiple sites. Names change frequently in the business of acquisitions in healthcare (Assura has been bought out by Virgin Health). Some have multiple labels and brand themselves as NHS, because they are seeing NHS patients. Would the average man in the street really regard this sort of provider as equivalent to pre-existing NHS services?

A community service, cherry picking patients with easily diagnosed and treated disease,

leaves itself open to the accusation that it is profiteering from the current NHS tariff, originally set up to reimburse hospitals fairly for the panoply of dermatological diseases that secondary care has seen and treated. Historically, easy cases subsidised the more complex skin conditions. If community private providers are not integrated with the acute trust provider (and this is unfortunately often the case) this leads to double-handed and double costs across the pathway. Additionally, this results in a flux in staffing for traditional NHS secondary care and undermines the Sustainability and Transformation Plans (STPs) announced in the NHS planning guidance in December 2015.

Hospital budgets are in the red to the tune of £2 billion [10]. It is hard for collaboration to flourish given the competition model of the Health and Social Care Act of 2012. Doctors are crucial to good management [11].

The NHS has a duty to break even but should not select its customers. It operates in an emotive area, intensively scrutinised by the media while subject to national and local political pressures [12]. Dermatology in the NHS can only be as effective as the environment in which it is allowed to operate.

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The Centre for Health and the Public Interest (CHPI)

The CHPI (www.chpi.org.uk) was conceived as a think tank committed to the founding principles of the NHS which would inject a critical voice into the mainstream discourse on health policy, which had been dominated for three decades by market ideology.

We aimed to make good evidence and an objective style the defining characteristics of our reports, and hoped that with skilled media promotion we might be able to make it hard for the mainstream to ignore them. We also hoped that if our reports were clearly and simply written they would prove useful to activists.

Planning began in 2009 but was interrupted by the 2010 election and the introduction of Andrew Lansley's Health and Social Security Bill. We eventually began operation in June 2013. Since then we have published seven research-based reports and eleven 'analysis' papers, plus a large number of blogs – most of which we commission and which we try to hold to the same standard of evidence as our reports and papers.

Our first report, *Healthcare Fraud in the New NHS Market – a threat to patient care* [1], pointed to the risk of large-scale fraud that is implicit in large-scale outsourcing of clinical work to for-profit providers, and the enormous scale of such fraud in the US, even though legislation to police and penalise it is far more developed there than it is in the UK.

Our second report, *The Future of the NHS? Lessons from the market in social care in England* [2], showed that four features of social care marketization were liable to be repeated in the NHS: a rapid expansion of private provision; a loss of quality; deregulation and casualization of the workforce; and failures of private providers, threatening patient care and posing financial risks to the NHS. While these threats have been only partially replicated in the NHS to date, marketization of the NHS has also been relatively limited, thanks to the government remaining the 'single payer', and it has so far had only some 15 years to run. In the present political situation it would be rash to conclude that the dangers foreseen in the report have passed.

Our third report, *Getting Behind the Curve? Is the new NHS ready for pandemic flu?* [3], was written when pandemic flu was at the top of the government's health risk register, but it remains equally relevant in relation to other threats, such as Ebola or Zika. It showed that loss of institutional memory in the marketization process, the disappearance of a 'clear line of sight' for a Secretary of State trying to manage a health emergency, and the difficulty of co-ordinating increasing numbers of private providers of NHS services in a health care system underpinned by contracts, all pose significant risks, some of which cannot be overcome within a marketised system.

Our 2015 report on the outsourcing of NHS clinical work, *The Contracting NHS: can the NHS handle the outsourcing of clinical services?* [4], showed, in effect, that it can't. We sent Freedom of Information requests to all 211 CCGs and eventually received 181 responses. These revealed that close monitoring of the more than 15,000 contracts, worth a total of £10 billlion – a 50% increase over 5 years earlier – which CCGs and NHS trusts held with private providers in 2013-14 was not occurring; while a variety of scandals, from Serco's out of hours contract in Cornwall [5] to Winterbourne View [6], showed the serious dangers involved.

Closely related to this were two reports on patient safety in private hospitals, where half a million NHS patients are now being treated every year. The first of these reports, published in August 2014, was *Patient Safety in Private Hospitals – the known and the unknown risks* [7]. It demonstrated that in most private hospitals the distinctive features of their facilities (lack of intensive care beds), their staffing (no specialist teams or on-call anaesthetist rotas, and only a single Resident Medical Officer on site) and their governance (Medical Advisory Committees composed of doctors with practising privileges, with a built-in conflict of interest) presented distinctive safety risks. It also revealed a general lack of detailed information on private hospitals' performance, due to their not being subject to the same reporting requirements as NHS hospitals. This report was acknowledged by the Care Quality Commission as playing a role in the design of a new CQC inspection regime for private hospitals. A study of the first 15 CQC reports to be published under this new inspection regime led to a second CHPI report, *How Safe are NHS Patients in Private Hospitals?* [8], published in November 2015. It found that safety problems in these hospitals, including some large and well-known ones, were extensive, raising serious questions about the continuing use of private hospitals for the treatment of NHS patients.

Over time our reports have come to attract a lot of attention, with coverage in *The Times, Independent, Telegraph,* and in BBC news and other programmes, plus citations in Parliament and by the BMA and other organisations. But some of our analysis papers have also been widely cited, including, among others, Professor Calum Paton's 2014 paper, *At what cost? Paying the price for the market in the English NHS* [9], which still provides the best available detailed analysis of the cost of the market; Professor Marianna Fotaki's analysis, *What Market-based Patient Choice Can't do for the NHS: The theory and evidence of how choice works in health care* [10]; and Dr David Bell's review and critique, *Mental Illness and its Treatment Today* [11].

We have no illusions that our work has done more than contribute to exposing the failure of the market model, and we are well aware of the dangerous situation the NHS is now in. But we have had more impact than we dared hope, and we mean to have more in the future.

By December last year, however, we had reached the limit of what could be done on the basis of purely voluntary work by already overworked people, and paused our research, while continuing to publish blogs and analyses, notably on Simon Stevens' Sustainability and Transformation agenda. But in September we will resume research operations with a full-time research officer, a new home with the medical charity Medact, and an expanded and rejuvenated management team. We only need an expanded income, having so far operated on a shoestring of under £15,000 a year. We would greatly welcome any contributions of advice, time, and of course funds*.

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Please help the CHPI by donating what you can: https://chpi.org.uk/get-involved/

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The State of the Nation

David Wrigley was recently voted in as BMA Deputy Chair (see page 6). In a piece written earlier for *Health Campaigns Together News* (reproduced abridged here with permission), he summarised what the latest BMA ADM meant for members, and the underlying issues facing the profession.

GPs are angry and many near to collapse; Junior doctors have rejected the latest contract offer and are deciding what to do next; and the country reels after Cameron's disastrous bungle and lost gamble over the EU, making all our futures more uncertain. What did the doctors' BMA annual conference make of it?

400 doctors recently gathered in Belfast for their annual meeting to discuss issues affecting the whole profession. It is a a very busy week.

GPs were angry this year. Angry at how their branch of practice has seen yet more cuts to their budgets and angry with politicians who make out things are OK when those of us working on the front line of the NHS know it isn't.

GP surgeries are closing across the country now. GPs can no longer keep going and are handing their keys back to NHS England. What a shocking indictment on our politicians when their policies and funding cuts bring about the closure of much loved and well-respected community surgeries. Patients are the ones who lose out and once a surgery closes it will never come back again.

The workload is intolerable with upwards of 60-70 patient contacts a day, 30-40 blood results a day, 20-30 hospital letters to deal with,

numerous telephone consultations and a few home visits thrown in for terminally ill patients whom we increasingly care for at home now in their dying days.

Much of this was discussed in Belfast and the profession has demanded a rescue package that will go some way to save our profession from collapse.

If nothing comes about by the autumn, then the BMA has been given the go ahead to ask GPs whether they will consider industrial action. This is how bad things have got. General practice used to get around 12% of the NHS pie to fund its work and this has been gradually eroded by our politicians to around 7% now.

That is nearly a 50% cut when workload has rocketed and the complexity of the work we do has increased significantly. We now see patients with up to 8 co-morbidities such as diabetes, heart failure, renal disease, hypertension and COPD. Often they are on 10-15 different medications and juggling all of this in a 10 minute appointment is nigh on impossible. The chair of GPC, Dr Chaand Nagpaul, said in his conference speech this was "not possible, not sustainable, not safe" (https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-latest-news/arm-chair-speech).

Dr Napgpaul went on to say how shameful it was that when we are the worlds 6th richest economy that we have some of the lowest number of hospital beds in Europe and very low numbers of doctors and nurses. He accused politicians of "savagely slashing NHS funds under self-proclaimed austerity".

Another big issue at the moment is the junior doctor dispute. We recently saw a ballot of junior doctors and medical students reject the contract by 58% to 42% on a 68% turnout. On the day this was announced the chair of JDC Dr Johann Malawana resigned as he had recommended the contract to his colleagues and given they had rejected it he felt he had to leave.

Dr Ellen McCourt was elected chair the next day. Ellen is an A&E trainee from Hull and has a lot of work ahead of her. JDC have decided to survey its membership over what steps they might be prepared to take next.

You will have seen that Mr Hunt got up in Parliament days after the result was announced and announced he would be imposing the contract. This has led to a group of junior doctors (Justice 4 Health – http://www.justiceforhealth.co.uk) consider legal action against the actions of Mr Hunt. We will have to see where all this gets us*.

> "Our patients must come first...we must hold to account those who put this aim of ours at risk and speak out on behalf of our patients."

All this is at a time when the major political parties in turmoil and the country has voted to leave the EU. It is hard to think of a time when so many momentous events have come together at once like this.

One thing we must remember is that our patients must come first in all we do. Despite the savage cuts to the NHS and the dwindling workforce we must do all we can to ensure patients receive safe, high quality care.

We must hold to account those who put this aim of ours at risk and speak out on behalf of our patients when we believe we see injustice occurring. That is as true to the heart and spirit of medicine as surgery as giving out prescriptions. .

**Since this article was first published, Justice for Health has achieved a victory in getting the High Court to agree that its case against Jeremy Hunt can proceed for less than half the "security" of £150,000 demanded by the NHS Employers before the civil case could even be heard.*

David Wrigley

Blow the Whistle and Dodge the Bullet

How safe are doctors raising concerns in the NHS? You might be safe but we cannot be sure.

This is a statement that might shock or might be something implicitly doctors are aware of, it's sad but true.

As a direct result of my personal experience and encouraged by a number of people I founded a network of whistleblowers, with the primary objective of raising awareness, and ensuring that government became aware of the challenges that we face in the NHS.

In 2012 Patients First co-organised a conference on whistleblowing hosted by the BMA, and many doctors who had experienced bullying as a result of speaking up shared their experiences. The campaign further developed, and we have helped a number of individuals to build resilience whilst they work through the system. There are many whom we haven't been able to help in any really practical way, and this just fuels our campaign even more. Until we see really meaningful change brought in to protect frontline staff we will continue to campaign.

The demand for advice and support from Patients First has been significant. This tells us that the problem of not being safe to speak up is a system-wide problem, and not about the individuals.

Due to the number of people contacting us, we started to recognise patterns, and to collate narratives. In a short period of time we collated 70 narratives of NHS whistleblowers, across medicine, nursing, and management. Many additional contacts were too afraid to share their story, or wanted to forget the experience, which for some is traumatic, and life changing. It can be therapeutic just to be listened to and believed, and writing down your story can help but could also reawaken the trauma, so for each person the decision was personal.

Doctors raise concerns on a daily basis and will not necessarily suffer harm, but if they do the commonest harm is bullying. Trouble arises when we witness, fear or experience something so serious that we need to pursue it. Speaking up is enshrined in our professional code of conduct, that we must put the needs of our patients first. It's built into our contracts of employment that we have the right to speak up about patient safety risks, overriding any loyalty to our employer, if needs be, that is for patients. The reality of course is that speaking up externally to your employer can lead to suspension, disciplinary action or dismissal. Often we don't know what the response will be until it is tested out.

As I write this it comes to mind the myriad ways that transparency can be blocked. Firstly, doctors are generally respectful of the hierarchy. We respect our elders. Medicine is a complex profession; knowledge and experience count. It takes years to accumulate both. We are generally deferential to our seniors, believing that they are pursuing what's right for patients above any other agenda. But, where power and status rides on clinical excellence, where a positive reputation is a highly sought after, the push for transparency can so easily be challenged. Shall I turn away from this mistake to avoid upsetting my colleagues or seniors? Should I risk rocking the boat and lose this job/career/status I have sacrificed so much to achieve?

What can happen is that the patients can be forgotten in the scramble to protect oneself.

Patients come to harm, around 10% of the time in acute situations. We speak about wanting to reduce avoidable harm and that can

only happen if we adhere to the principles of openness and transparency, at every level within an organisation.

What will make the difference to health professionals? why are there so many difficulties?

The law that supposedly protects NHS staff in speaking up, The Public Interest Disclosure Act 1998, " PIDA", part of employment law, fails , because it can really only come into play after an individual has been dismissed or suffering other punishment. PIDA does not oblige an organisation to investigate a patient safety concern.

It does not make voicing concerns for workers easier, for example by providing a statutory mechanism for whistleblowing. The fear staff feel about speaking out on public interest issues remains. There are no statutory obligations on organisations once a concern is raised, even to investigate that concern. Patients First developed an early intervention scheme which was submitted to the Department of Health and NHS employers back in 2012, and as yet we haven't seen any progress. We see this lack of immediate response as the key problem that fails staff raising concerns.

If an employer takes a dim view of concerns being raised or complaints of bullying being lodged, we have some evidence, of threats to prevent re-validation [1], or invoke disciplinary procedures. John Hendy QC [2], some years ago, contacted me to inform me of the unfair system of Maintaining High Professional Standards (MHPS):

> **"Doctors referred to the GMC have legal representation. Yet such protections do not exist for a doctor whose professional reputation, career, vocation and livelihood are at stake in disciplinary proceedings brought by his or her employer."**

The MHPS process was ratified by the BMA so it is not feasible for lawyers to easily challenge on an individual case basis.

The ratification of this system for doctors by the BMA has failed many doctors. The employer if so minded in cases where MHPS has been invoked act as judge, jury, and executioner.

Trade unions and professional bodies are expected by staff to support those who raise concerns over patient safety and public interest issues. Yet with some exceptions those who contact us express deep disappointment in respect of the three health care unions representing doctors nurses, and midwives.

Patients First recognise the challenges that unions face in legally representing whistleblowers with the current legislation, and system, but we strongly feel that unions should be campaigning to have the law tightened and to end gagging clauses, and address bullying in the workplace. On these keys matters related to whistleblowing unions have been effectively silent.

> "Once a whistleblowing matter turns into an employment dispute the drive seems to be on agreeing a financial settlement rather than pursue the patient safety matter, and protect the public. Members expect trade unions to stand their ground."

Once a whistleblowing matter turns into an employment dispute the drive seems to be on agreeing a financial settlement rather than pursue the patient safety matter, and protect the public. Members expect trade unions to stand their ground and protect their rights. They frequently report feeling let down and that there ends up being a battle with the trade unions as well as the employer. We believe that unions should review their policies and training on whistleblowing and be open about what support members can expect.

Campaigners have also pressed for an

independent body dealing with concerns raised by staff, a staff support commission, whose functions would include dealing with NHS whistleblowing issues, with a dedicated Whistleblowing unit [3].

The health select committee in its fourth hearing on raising concerns and complaints published in February 2015 stated that whistleblowing is a stain on the reputation of the NHS. This cannot be allowed to continue [3].

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Kim Holt
Patients First

Patients First is a campaign network of health professionals and their supporters. Their purpose is to reduce death and harm in the NHS by campaigning for the UK government to create policies and laws that ensure that the NHS becomes open and accountable. They will actively support all those who raise concerns about patient safety. They can be followed on twitter @ PatientsFirstUK

A good start?

NHS Improvement – a Quango that "brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams" – issued what it claimed to be "a policy for the NHS" on whistleblowing in April 2016.

Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS (https://improvement.nhs.uk/uploads/documents/whistleblowing_policy_30march.pdf) is an 11 page document that is aimed at "improving the experience of whistleblowers in the NHS". It goes on:

"It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients."

It then lists the nature of what can be raised as a concern, how staff can feel more safe, confidentiality, who to raise concerns with and details of the prposed procedure, which includes escalation ot external agencies. Annexes give examplars of going through the process, and a colourful pie chart as a "vision for raising concern in the NHS". This has all the hallmarks of being a wish-list: but change has to come from somewhere so ideals are as good a place as any.

Laudable and arising straight from the Francis Inquiry. But, as the preceding article makes only too plain, will it shift the currently far from laudable "point, blame and run" culture that pervades much of the NHS? People suffer from this and careers are ruined.

The White Coat Effect: Off the Cuff Science?

How losing sleeves hid the truth

The white coat edict

Hospital scenario

- There is an outbreak of infection in hospital.
- This occurs in many hospitals across the whole country.

Cause

There is a shortage of beds in hospital.

Therefore the patients being looked after by individual consultants are scattered between different wards, depending on where there is an empty bed when each patient was admitted.

This, in turn, means that consultants checking their patients have to go into many different wards, and they are accompanied by the junior doctors in their team.

In addition, the individual junior doctors also have to go backwards and forwards between the different wards every day, taking the patient's history on admission, plus organizing X-rays and blood or other tests,

Staff taking the specimens, taking X-rays, and physiotherapy, if necessary, and for any other reason, all have to move through many different wards.

Decision made by UK Chief Medical Officer in London

In December 2008, the decision is made that the cross-infection is being caused by the white coats worn by doctors carrying infection round the wards.

A nationwide diktat is issued:

1. All doctors must no longer wear white coats – because they catch all the ever-present pathogens, aerosols, splatter & spillages, and transport them from one ward to another.
2. All doctors must no longer wear ties – because they can fall into the wound and/or interfere with a proper examination of the patient.
3. All doctors must wear short-sleeved shirts, and must remove their watches, jewelry and pens – because otherwise they will be unable to wash their hands properly between patients.
4. The incidence of infection will be followed up.

Outcome, as reported by UK Chief Medical Officer

> **"The incidence of cross infection is reported to have fallen markedly, therefore the white coat ban and the other diktats have been proved successful."**

Long-term follow-up by the UK Chief Medical Officer

None.

Follow-up by others

Consultant bacteriologist, Dr S.J. Dancer

Dr Dancer noticed that the official follow-up, only looked at the incidence of two pathogens *Clostridium Difficile* (CD) and Methicillin-resistant

Staphylococcus Aureus (MRSA). As was claimed, there had indeed been a fall in infections in hospital caused by these two "bugs". "Was the removal of the 'white coat', and associated hygienic gestures a key component of the declining pathogen rates? No it was not". The incidence of ward infections by other pathogens showed no change, and the incidence of CD acquired at home was rising. "The increasing number of patients presenting to their GPs with CD cannot be due to malevolent white coats loitering in the bushes, naked forearms or any other dress code component."

The "white coat" was a scapegoat for Hospital Acquired Infections (HAI). It was used so that the authorities could ignore all the other potential drivers of hospital superbugs. Crowded wards, A&E overspill, inadequate clinical staff, lack of isolation facilities, poor cleaning, and disinterest in infection control, all constitute a rather costly challenge to put right. "Lopping off all those cuffs was the easiest (and cheapest) thing to do."

Response by Dr B.J. Duerden from the Department of Health

He stated, that "there was general agreement that, within (their) management ethos, the only way to get the necessary attention, and focus on the prevention and control of healthcare associated infections, was to have targets for which Chief Executives were held accountable."

Dr Duerden also emphasized that "the 'dress code' had come from a group of the most senior medical and nursing officers in the Department (of Health) of which he was one, with the support and endorsement of the then Minister of Health in the House of Lords, Lord Darzi, an eminent and respected cancer specialist."

Dr Duerden had been "challenged on numerous occasions to quote the scientific evidence – the double-blind clinical trials as done for new drugs – that long sleeves caused cross-infection." NO tests had been done to prove their hypothesis but they felt it was unnecessary because the purpose had been to alert medical staff to the importance of protecting patients from cross infection.

Other Comments

An introductory paragraph, plus the full articles contributed by both Doctors, Dancer and Duerden, were published in the *Journal of the Royal College of Phyisicians of Edinburgh* [1].

Conclusion by Dr S.J. Dancer

The white coat protected the wearer from ever present pathogens, aerosols, splatter and spillages. Without the white coats the dirt and infection hits the everyday clothing that doctors are wearing. The families of medical staff therefore have a greater risk of infection being brought home. White coats can be easily washed, though current NHS Management would object to the cost of regular washing.

An additional purpose of this whole exercise had been to demean the status of medical consultants, and all doctors, in the eyes of the general public, because doctors carried too much respect and authority.

An outsider's perspective by Dr E. Lloyd

I had retired before the "white coat ban" had been imposed. My first contacts, as a visitor and/or as a patient produced something of a surprise. None of the doctors were wearing a white coat, or ties. I then heard about "the diktat", and my initial presumption was that there must have been a very good, and proven, reason for the implementation of the "diktat".

The publication of the articles, by Drs Dancer and Deardon, opened my eyes.

The claim by Dr Duerdon, that the "diktat" had been written "by a group of the most senior medical and nursing officers" only told me that they had long since completely lost touch with the reality within hospitals.

The statement that, "within the management ethos, the only way to get the necessary attention and focus on the prevention and control of healthcare associated infections was to

have targets for which chief executives are held accountable", sounds more like supermarket management jargon than a medical response. This is not really surprising since Mrs Thatcher had consulted Lord Sainsbury on how to create a management system for an organisation with multiple outlets, of varying size, located across the UK.

Additional damage caused by the absence of the "white coat" was that strangers, patients and visitors, could no longer be sure who was a doctor who could be approached for information and/or advice, eg "where is ward x?" or "who can I ask about the condition of eg a relative?"

Life before Thatcher

The traditional organization of hospital care was based on individual wards under the authority of a ward sister who had the responsibility for, and the authority over, everything that happened in that ward.

This included the ward cleaners, who were attached to a single ward. They provided a very high standard of cleanliness, not only because they had been trained by the ward sister, but also because the felt that they were a part of the team and took a pride in the cleanliness of their ward.

A night sister supervised several wards at night, with frequent visits, and a matron was responsible for all nursing activities in all the wards, and with a medical superintendent, provided all the administration necessary. The health board was able to function at a distance and required very few people.

Privatisation

The first group of hospital staff "privatised" were the ward cleaners. Now supplied by outside contractors, they have had no special training, and no knowledge of medical matters eg the same mop and water would be used in the ward, the toilets, and the treatment and cooking area, in random order. They would not take orders from the ward sister. Their employers, more interested in making money than in the care of patients, could, and did, reduce the time allocated to each ward, and the rate of pay. This obviously increased the risk of the transmission of infection.

One proof of this was when the New Edinburgh Royal Infirmary (ERI) was built. A statement was given to the local BMA by a professor of bacteriology, that "because the new ERI was a 'state of the art' hospital, there would be NO problem with infection". Unfortunately the private contractors forgot to allocate cleaners for the hospital, with the result that the brand new ERI initially became notorious for its rate of hospital acquired infections.

Conclusion

Two major articles, and a response, have been published in the *Journal of the Royal College of Physicians of Edinburgh*, a very reputable medical journal with a wide circulation [1-3].

Why have these three contributions, examining a major cause of health problems, been met with absolute silence?

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Evan Lloyd

In Pursuit of a Local Microbiology Service

New Zealand's pathology services herald what is happening here

I am the medical lab scientist who formerly managed the laboratory in the public hospital in Whakatane*, New Zealand. I also set up the Hepatitis Foundation of New Zealand which cares for around 14,000 HBV and HCV carriers.

In the past, the Whakatane Hospital Laboratory handled all clinical laboratory specimens from the hospital and from general practitioners (GPs) in the whole Eastern Bay of Plenty (EBOP). This was on audit, an efficient model.

Our lab would have been highly profitable had we been paid at the same rates as were State-funded "private" labs. In the late 1990s a distant private laboratory was allowed to take over the GP work, with predicted effects on the hospital laboratory, which was not permitted to compete for the work.

The hospital lab lost over 50% of the workload and became inefficient and a target for future takeover by for-profit laboratories. Specimens from most GPs were from then on couriered to Tauranga, 90 km (56 miles) distant. GPs and patients were unaware that every specimen would arrive in Tauranga many hours late. The expected take-over of the hospital laboratory took place in 2010 when our District Health Board (DHB) awarded a contract to the private lab in Tauranga in the face of strong opposition from residents, doctors and other health workers, who invited me to lead a campaign seeking a return of a full onsite microbiology service for both the hospital doctors and the GPs in EBOP communities. In 2011, 29 of 30 Whakatāne Hospital Senior Medical Officers (SMOs) signed a memorandum to the BOPDHB, complaining strongly about the planned downgrade and the lack of consultation. They were beaten down.

A year later the Whakatane hospital microbiology department, whose audits by our international accreditation agency frequently bettered that of the Tauranga labs, was "disestablished". Since then "urgent" microbiology specimens have been processed here in Whakatāne. "Routine" specimens have been couriered to Tauranga.

A problem was that the best microbiology scientist was amongst the staff laid off (the price he paid for opposing the downgrade), and others left; some resigning in protest. Thus the more pressing urgent work was left to a staff which had diminished in numbers and expertise. Another problem was and remains; that of deciding what is "urgent". Our principal concern is that almost all microbiology specimens from Whakatāne and adjacent communities arrive in distant Tauranga so late (4-48 hours) that they fail to meet internationally accepted guidelines for processing such specimens. Many overseas labs decline to process specimens so late.

Considering the time and effort required by patients and doctors to provide some of the specimens in a large geographical area, and the lower overall cost of doing this right, the least one should expect is prompt handling and reliable reports. We get neither.

A petition (Petition 2011/20 of Alexander Milne and 4,141 others) was presented to parliament's Health Select Committee (HSC). 4142 residents of the Eastern Bay of Plenty signed the petition seeking the return of a full microbiology service for Whakatane hospital and nearby GP patients. It was one of the most supported petitions per capita in New Zealand's history. Many signatories were doctors or other health professionals and included former mayors. I addressed parliament's HSC on our submission. The DHB had sent a rebuttal which

was astonishingly inept and contained many errors of fact.

The HSC was in a quandary and so sought advice from the Ministry of Health, which, even though it had over 1,000 staff, contracted a private pathologist to provide advice. The pathologist failed to consult patients or any of the community or hospital doctors who had sent me reports regarding failings in our microbiology lab service (late reporting, inappropriate use of antibiotics, extended stays in hospital etc.). The only GP member on the BOPDHB was ignored (he was our strongest supporter), as was myself, despite the ministry being well aware that I represented EBOP communities.

The "consultant" contacted only the private laboratory and not the complaining doctors and patients, and advised the ministry that the Eastern Bay of Plenty received a "best practice" microbiology service. Astonishingly, she attached an 11 page set of CDC guidelines (*Manual of Clinical Microbiology*) which contradicted her assertion on almost every page.

She could not herself have read the guidelines from the book by ex-CDC expert Dr J. Michael Miller with whom I corresponded. The ministry forwarded that advice to the Health Select Committee, whose majority membership (from the governing party), then rejected our petition. Opposition parties presented opposing minority reports which were ignored as the policy was forced on us.

A second petition (Petition 2014/21 of Alexander Milne and 105 women) has been submitted to parliament asking that the House summons Ministry of Health and Bay of Plenty District Health Board officials and seek an explanation for the many omissions, errors, and misinformation which led to the rejection of petition 2011/20 of Alexander Milne and 4,141 others.

The chair of Parliament's Health Committee has just advised me that his committee will resume consideration of our petition soon. They know that in other parts of New Zealand, the transport problems are even worse. We in New Zealand have public/private mayhem where specimens are couriered hundreds of kilometres, bypassing fully accredited public labs which are often only minutes away.

The first step we must take to tackle the problem of emerging bacterial resistance is to ensure prompt identification of pathogens and responsible use of antibiotics. We must strive for excellence and higher standards, and resist any downgrading of clinical microbiology services. Downgrades need to be reversed. In New Zealand, the state funds our police force to protect us from criminals, and generously funds our military to protect us from non-existent foreign invaders, yet allows for-profit providers to manage far more likely threats. And these providers are so busy competing that they have lost sight of the needs of doctors and patients.

In New Zealand, inappropriate use of antibiotics is widespread. Most is prescribed empirically. Failures are common.

I have publicly alerted health officials and communities to the fact that I will soon release an expose on the tactics and strategies used by our government, health officials and state-funded private pathologists to manipulate patients, doctors, news media, community leaders and even parliamentarians, into believing that transport delays are a trifling issue, and that it is more efficient to do this wrongly, and that profit labs are the best providers of the vital service of diagnosing and managing infectious diseases.

Alexander Milne and the New Zealand Campaign Team
Facebook: @microbiologyactionNZ

*Whakatane is a town in the eastern Bay of Plenty Region in the North Island of New Zealand, 90 km east of Tauranga. Whakatane has an urban population of 19,300; the Bay of Plenty's third largest urban area behind Tauranga and Rotorua. Another 15,300 people live in the rest of the Whakatane District. Around 40% of the district's population have Maori ancestry.

Best Practice Guidelines: A Dangerously Low Bar

The guidelines for microbiology services in the UK leave much to be desired: Is there a political agenda here? And what can be done?

I was appointed medical microbiologist at North Tees Hospital in 1987. Until my appointment the laboratory was overseen by a senior histopathologist – originally a general pathologist. The Standard Operating Procedures I introduced were based on the ASM (American Society of Microbiology) Guidelines.

The ASM guidelines were uncompromisingly based on expert opinion and supported by robust clinical and laboratory data so I reasoned that the recommended laboratory procedures were likely to yield clinically reliable results.

Needless to say, having to work within the budget allocated to me, I had to adjust working practices – but always striving towards the ideal. In this I was ably supported by Medical Laboratory Scientific Officers (MLSOs) who shared these ideals, were enthusiastic about improving the service and were disinclined to follow "shortcuts" taken in other laboratories. The quality of the specimen was of paramount importance. As stated in the current guidelines from the US (*IDSA Guidelines*) [1]:

> **"Clearly, all microbes grow, multiply, and die very quickly. If any of those events occur during specimen collection, transport, or storage, the results of analysis will be compromised and interpretation could be misleading. Therefore, attention to preanalytical specimen management in microbiology is critical to accuracy."**

The key issue is the interval between specimen collection and culture in the laboratory. The IDSA document recommends that transport times for specimens for bacteriological culture should be 2 hours or less. Changes which contributed to this included the introduction of the pneumatic tube system for rapid transfer of all pathology specimens from within the hospital for immediate attention. Out of hours, however,, microbiology specimens accumulated until senior MLSOs participating in the on-call rota out of hours volunteered a visit to the laboratory at around 10 pm by the MLSO on-call to process positive blood cultures, incubate blood cultures taken during the evening, and culture any other specimens not noted as urgent but which they thought required immediate attention.

This has included specimens from "? Necrotising Fasciitis" and other specimens taken during surgery, specimens from patients with severe sepsis and on one occasion a CSF labelled "routine" which turned out to be a probable mycobacterium infection!

One of us (MLSO or consultant) was always available to attend if gonococcus infection was suspected, to provide plating at the bedside and transport to the laboratory in an old-fashioned candle jar. We were also fortunate in that a patient examination room was available within the laboratory suite. We used it to improve specimen quality by taking samples ourselves from patients with suspected fungal infection or with chronic wound infection but it also meant that a patient from the community could provide a fresh specimen when indicated.

Regular audit of transport delays with feedback of data to individual clinical units by ward highlighted our commitment to this issue and helped educate specimen procurers. A problem remained with transport of specimens from the community. For many reasons beyond our control, specimens from the community were

subject to delay. This was an insurmountable problem at that time.

Working within a budget meant we could improve quality only if we saved on inappropriate specimens and inappropriate follow-up of cultures. For instance, we focused on reducing those "routine" MSUs for "C&S" from the elderly which apart from the cost, we feared also led to inappropriate antibiotic use. When such specimens were received with no supporting clinical data, the justifiable comment "We are unable to process this specimen and provide a relevant report in the absence of clinical data" was returned. This was not popular – especially with General Practitioners - but it did have an auditable educational impact. And sadly, the practice was not supported by CPA inspectors.

An ill-given guide?

My concern with UK guidelines was that standard guidance was less than optimal. The current UK *Standards for Microbiology Investigations* (SMI) developed under the auspices of Public Health England illustrate my point.

With regard to specimens of urine, the UK SMI advice is: "Specimens should be transported and processed within 4 hours if possible" But of two references cited, one clearly recommends a 2 hour interval!

"If processing is delayed for up to 48 hours, refrigeration is essential". This is stretching it – culture within 8 hours and a maximum of 24 hours would be rational if the aim is to limit the overgrowth of contaminants. (What would you do with a shop bought sandwich?)

"Alternatively, the specimen may be collected in a CE marked leak-proof container with boric acid preservative. This increases the maximum permissible time for transport to the laboratory to up to 96 hours" The single cited reference recommends a delay of up to 48 hours. I am not aware of any publication which endorses storage for 96 hours in boric acid in view of its inhibitory effect. The comment which follows –

"It should be noted that boric acid may be inhibitory to some organisms" – is a gross understatement. This effect is more serious than is implied here. It is an issue which needs to be highlighted as does the problem of urine samples from infants and children when the volume of urine is insufficient in proportion to the preservative in the transport tube.

The IDSA recommendations regarding transport of urine specimens are:

"Refrigerate (4°C) or use urine transport tube unless delivery to laboratory ≤ 1 h is certain."

The duration of preservation capacity is not defined. The onus is on the laboratory to determine the adverse effect of the preservative used, in collaboration with the provider of the transport medium – the usual range being 24 to 72 hours.

The UK SMI's recommendation for pus and exudates states that:

"Specimens should be transported and processed as soon as possible"

This is non-specific and is open to interpretation. However, the single reference cited is in fact the IDSA guidelines referred to above, which is clear about the 2 hour interval!

The IDSA guidelines for such specimens are:

"Tissue, fluid, aspirate, biopsy, to be transported immediately and swabs (2nd choice) in transport medium within 2 h."

"The time from collection to transport listed will optimize results; longer times may compromise results"

The ideal is stated clearly and the risk entailed by non-compliance is highlighted. They are best practice guidelines which optimise the likelihood of obtaining accurate early laboratory results leading to better patient management and a reduction in antibiotic use.

What of the UK SMIs? Are they best practice guidelines or minimal practice guidelines? They are in fact neither. The document declares that SMIs "… represent neither minimum standards of practice nor the highest level of complex laboratory investigation possible."

They certainly do not represent best practice but I am taken aback to learn that they do

not even lay down minimum standards. I am concerned because it is also noted that "Commissioners of healthcare services use SMIs to find the standard of microbiology investigations they can seek as part of the clinical and public health care package for their population".

If these aren't minimal standards, does it mean that the standards could be lowered further if commissioners were so inclined? This curious state of affairs is clarified within the document: "The recommendations made in UK SMIs are based on evidence (e.g. sensitivity and specificity) where available, expert opinion and pragmatism, with consideration also being given to available resources."

Perhaps some consideration has also been given to the emerging pressure to centralise laboratory services – so transport delays have been identified as acceptable. Working within available resources and political pressures is a challenge which many of us face but the quality of patient care surely is a priority. Furthermore, the evidence showing that early microbiology results reduce antibiotic use must be acted on as it is crucial to dealing with the critical issue of antibiotic resistance. Doern et al [2] showed that a group of hospitalised patients assigned to receive rapidly reported bacterial identification and antimicrobial susceptibility tests had a lower mortality rate, underwent significantly fewer procedures and incurred significantly lower laboratory and pharmacy costs than a control group assigned to receive routine overnight reports. Numerous complementary studies show that early use of the appropriate antibiotic improves survival following bacteraemia.

Spell out the risks

I believe the ideal is to produce best practice guidelines based on expert opinion leaving it to individual practitioners to identify what is practicable. If guidelines are watered down for any reason, risks must be made clear to users. User information brochures should inform clinicians about the repertoire of tests available and the standard of laboratory services they should expect for the investigation of infection in their patients. Identifying the risks and deficiencies of the service enables users to respond appropriately by:

1. Making arrangements for dealing with specimens which may otherwise be compromised, eg on-site collection of urine for immediate culture avoiding the use of borate.
2. Persuading the provider to improve the service.
3. Bringing some pressure to bear on the institution financing the service.
4. Lobbying local politicians.
5. Appealing to the relevant College.

Or, as in New Zealand, taking it to parliament!

References

[1] Baron, E.J., Miller, J.M., Weinstein, M.P. et al. (2013) 'A Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: 2013 Recommendations by the Infectious Diseases Society of America (IDSA) and the American Society for Microbiology (ASM).' *Clin Infect Dis* 57:e22-e121.

[2] Doern, G.V., Vatour, R. Gaudet, M. and Levy, B. 'Clinical impact of rapid in vitro susceptibility testing and bacterial identification.' *Clin Microbiol.* Jul; 32(7): 1757–1762.

Malila Noone

Conference Report: WONCA Europe 2016

What has the EU ever done for us? This question crossed the minds and lips of most of us during the EU referendum debate and when I first heard of WONCA and WONCA Europe, aside from thinking of chocolate, I assumed these to be more irrelevant, impenetrable European committees.

This summer however, I was grateful to receive a bursary from the RCGP to attend a WONCA Europe Conference to find out more.

First, a quick overview. WONCA is The World Organisation of National Colleges and Academies and Academic Associations of General Practitioners; or simply, The World Organisation of Family Doctors. WONCA's principle aims are to support an international network of GPs for the purpose of knowledge sharing and collaboration, and also to represent the GPs in its member countries on the international stage, interacting with the World Health Organisation and other national, regional, and global groups. As well as hosting an annual conference, its regional councils, of which WONCA Europe is one, also hold their own annual conferences. This year, the WONCA Europe conference in Copenhagen focussed on five key challenges facing GPs across the continent: ageing populations, affordable healthcare, future consultations, diagnostic difficulty and addressing inequalities.

> "A fascinating insight into the shared challenges and unique solutions our general practice colleagues face across the continent...I have come away buzzing with new ideas."

Across Europe, there is growing interest in using telemedicine to assist in providing rural healthcare, minimise the logistical difficulties of home visits and to improve access for busy patients. Video conferencing and email consultations are already being used in many European countries but whilst they improve accessibility, they do not necessarily save the GP time. A very novel technology being explored is remote consultation technology, whereby a medical technician would visit a patient, record observations and auscultate, and the GP would have access to this data and to the auscultation sounds via video technology in real-time, in order to offer a management plan. Throughout Germany, general practices also routinely have ultrasound machines, which all GP trainees are now required to be able to use as part of their training. This seems to have most benefit for diagnosing problems in early pregnancy and in soft tissue injuries.

Additionally, there was great interest in how the future of the profession may look with increasing demand but poor recruitment. One key-note speaker, Dr Martin Marshall, proposed a model whereby GPs would be part of a much larger primary care organisation consisting mostly of nurses, physician associates, pharmacists and medical assistants. The GP role would then evolve, such that half of one's time would be spent managing complex, multi-morbid patients and the other half would be spent training, mentoring and supervising the rest of the healthcare team who would be seeing acute and simpler medical problems themselves.

Professor Paul Glasziou delivered an excellent keynote address on increasing over-diagnosis,

attributing this to a combination of over-detection, expanding definitions of disease and medicalisation. In particular he raised an interesting ethical question: should authors of clinical guidelines have an obligation to consider the harms, in terms of further investigations and diagnostic labelling, as well as the benefits, before they publish their guidelines? Numerous workshops explored our diagnosis-led model of care and proposed an approach that is, instead, problem-led. In mental health, for instance, we reviewed a model that helped patients to tackle maladaptive cognitions, feelings and behaviours without necessary labelling them with a diagnosis.

Finally, as a means of addressing inequalities in healthcare, we heard speakers describe programs where general practices have expanded in their role to become holistic community hubs. A successful example of this model is the Bromley-By-Bow community centre which has re-established a strong sense of community identity in an economically deprived area. The services on offer include GP consultations, employment support, education and training, financial advice and social support, volunteer services, community art classes and exhibitions and wellbeing advice. Consequently, as remarked by Lord Mawhinney, it has grown to become one of the "most impressive displays of social entrepreneurship anywhere in Europe".

Perhaps the most valuable aspect of the conference however was being able to network with doctors from across Europe. Every European country is currently facing a recruitment crisis, with doctors disproportionately choosing hospital careers over general practice. Each country is facing monumental financial pressures following the economic collapse and this is driving a move to manage more people in the community but without the additional resources to do so. Strategies to address these problems vary.

In Denmark, tech-savvy doctors are creating a "dating-website" style matching system between GP trainers and trainees, to make the mentoring relationship more personal and specific. In Turkey, GPs have been rebranded as "Family Medicine Specialists" to bring more prestige to the role. Many other countries are exploring internet and digital healthcare as outlined above. Interestingly, one major difference in how we practice, which stunned our European colleagues, is the 10 minute consultation. In Iceland, GPs have 20 minutes per consultation and one Swiss GP I spoke with stated that she was allocated 45 minutes for a first appointment with a new patient. European doctors couldn't fathom how we could practice safely and comprehensively within our time constraints, particularly with increasing multi-morbidity, complex community care and mental illness; and I had to agree with them!

In conclusion, attending the WONCA Europe conference offered a fascinating insight into the shared challenges and unique solutions our general practice colleagues face across the continent. I have come away buzzing with new ideas having had but a taste of the quirky world of WONCA, where singing a tongue-in-cheek GP national anthem over dinner, or taking part in a 3000-person group karaoke as part of a closing ceremony, are the norm. I am very grateful to the Mersey RCGP for affording me this opportunity and I would strongly encourage every GP and GP trainee to attend.

Evan Lloyd

Website: http://www.woncaeurope2016.com

Obituary: Peter Draper

Peter Draper has died, at the age of 83.

A regular contributor to the *DFNHS newsletter* and a founding light in the organisation, Peter's contribution to public health and to campaigns defending the principles upon which the NHS was founded would be hard to under-state. His obituary in the *Guardian* [1] sums this up:

> **"He was instrumental in creating the study of health policy in the UK and was the country's outstanding public health practitioner in the second half of the 20th century."**

Several DFNHS members have commented on how the early meetings of the then NHS Consultants' Association were hosted at Peter's rooms at Guy's, London. Tributes to Peter have also included the following:

> **"In my view he was unquestionably the most important figure in UK public health in the second half of the 20th century. He single-handedly invented health policy and healthy public policy within the UK, and produced a superb series of reports from his Unit for the Study of Health Policy at Guy's Hospital Medical School.**
>
> **"Many of us enthusiastically moulded our approach to public health around Peter's example. A great public health physician."**
>
> *– Alex Scott-Samuel*

> **"Peter had a nice turn of phrase. In comparing 19th Century and more modern public health threats, he described tobacco and various other forms of advertising as 'pollution of the thinking water'."**
>
> *– Professor Mike Daube*
> *Professor of Health Policy*

Dr Peter Draper: 1933-2016

> **"I will remember Peter as a man who continued to campaign for as long as he was fit and able to do so. He always had useful things to say, said with a quiet voice."**
>
> *– Ron Singer*
> *Doctors in Unite*

> **"He was one of the original members of NHSCA. He was a prolific thinker and writer He was an active member of our Executive Committee for many years and then of KONP, continuing to contribute his thoughts and writings. In later years his activities were curtailed by bi-polar disorder with which he struggled bravely."**
>
> *– Peter Fisher*

Reference

[1] https://www.theguardian.com/society/2016/aug/22/peter-draper-obituary

Book Review

The Mystery of Being Human: God, freedom and the NHS
Raymond Tallis. Notting Hill Editions (http://www.nottinghilleditions.com/books)
215pp. £14.99 but with £3 discount

If you are lucky as a reader, you will find there are a few little books that address issues as profoundly as they are attractive to read. This was one for me, placing it in the same rare category as Tony Judt's *Ill Fares the Land***.**

It poses – and answers eloquently – questions ranging from free will to religion to the nature of consciousness, the place of maths in reality, and the significance of pre-recorded announcements on Virgin trains, amongst others (and the last one isn't trivial either).

But of most interest to DFNHS readers will almost certainly be Chapter 4: 56 pages addressing the parlous state of the NHS. This essay charts the history of the Health and Social Care Act and the mis-perceptions and shadows shrouding its true nature, teasing apart the fallacies as powerfully as pointing out its remorseless progress in undoing our NHS. Chomsky's dire warning about privatisation – defund, denigrate, privatise – is expanded to explain the agenda of devolution. The driver to this, increasing wealth for the already obscenely wealthy, is explained, and we are left in no doubt as to who to blame: Hunt et al.

The narrative is above all one of personal discovery. It lends this a sincerity that makes it all the more creative and undeniable. Of campaigning. Of people coming together to fight "the monster". Of trying to get the message across "on the streets". I was left feeling vindicated, encouraged and with my anger refreshed. A great little book, befitting Professor Tallis's impressive polymath career. Read it well. But don't expect to put it down easily!

Alan Taman

DISCOUNT
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http://www.nottinghilleditions.com/books
Enter the discount code **NHS01**

Annual General Meeting

Saturday October 1st 2016
Unite House, 128 Theobald's Road, Holborn, London WC1X 8TN

Including the Paul Noone Memorial Lecture by Professor Neena Modi:
"Efficient, effective, equitable"
Full details and application forms should reach members by mid-September. Duplicates from:
DFNHS, c/o Hill House, Great Bourton, Banbury, Oxon OX17 1QH
Phone & Fax: 01295 750407
e-mail: nhsca@pop3.poptel.org.uk

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