
NHSCA

EDITORIAL March 2014

Whistling for the Truth

Possibly the most important news relates to the proposal, made at an extraordinary meeting of the NHSCA Committee, to re-launch our Association under a new banner. Malila Noone gives the details and asks members to respond. This leads on to a critical look at ourselves, and how we have allowed our vocation to be poisoned by the politicians. More often than not we fail to be actively demonstrative about the way in which healthcare is delivered.

Our reluctance to take the high ground probably relates to professional etiquette, whereby we rarely if ever criticise colleagues regarding the diagnosis and management of patients. This is simply because we are well aware that the process of diagnosis is imprecise and that there is usually more than one way to manage a patient's clinical condition.

Outside the immediate confines of clinical practice we also realise that colleagues may have different attitudes towards service delivery and, in particular, the conflict of interest that may arise in regard to private practice. As a result we become so inhibited that we just knuckle down to giving our best shot to our patients whilst ignoring what is going on elsewhere. Is that the case, or have I missed something?

Being demonstrative means making waves that cause people to sit up and notice. Consider for a moment what the pop group, Pussy Riot, has done in Russia and got away with, in spite of the country's authoritarian political system. It was only ten days after they had taken their demonstration into Moscow's Russian Orthodox Cathedral that they were arrested. This was despite the insulting title and refrain in their track, translated into English, "Putin has pissed his pants". What would the UK establishment do if a pop group released a track with a title and refrain,

"Cameron has buggered himself"? You only need to remember the controversy that raged about the use of the word "Pleb" to realise that the UK is far less tolerant of verbal abuse than Russia.

In view of this I have devoted some of this issue to whistleblowing – a habit that we almost unanimously shrink from, and yet by so doing we condone the damage done both to individual patients and the NHS in general.

Whistleblowing

How do you define this word? It is rather like trying to define bullying – a subject which has assumed enormous proportions in recent times. A whistleblower should probably be defined as someone who has exhausted the usual channels of complaint and has gone public. Some people seem to think that whistleblowing is the first stage of any complaints process when issues are essentially raised in private. Whistleblowing involves publicity – publicity that may threaten the livelihood of the whistleblower.

There is little doubt that the furore in Colchester about their Cancer Services would never have arisen but for the public revelations of two lowly paid employees of Colchester Hospital University Foundation Trust (CHUFT). Their claim, that data was being deliberately falsified in order to meet Cancer waiting time targets, is currently being investigated by the police. The spin off was that, just for once, the Care Quality Commission (CQC) made a **thorough** visit to CHUFT in August 2013 and, following that, an external Intensive Support Team was sent in to make an in depth investigation, so that NHS England (NHSE) could make meaningful recommendations to change practices.

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Their report was published on 19th December. Press releases were issued by CHUFT and the Clinical Commissioning Group (CCG) stating an action plan lacking specifics and without any apology or admission of incompetence. The hospital's Chief Executive, who had spent a couple of years as a junior hospital doctor before spending the rest of his career in the Pharmaceutical Industry, withstood personal media crucifixion for a few weeks, before resigning. Most of the remaining Board members then appeared to jump ship with the exception of the Chairman who, like one of the three wise monkeys, had hidden high up in Monitor's Banyan-tree waiting for the figments of her imagination to ripen.

What no one had done was to explain to the local population just how complex cancer diagnosis and treatment had become, and where in that patient journey glitches had appeared and what had caused them. Consequently I prepared a comprehensive summary of the NHSE report with a view to it being published either as a press release or as an article in our Health Forum (HF) bimonthly Newsletter. I really should not have bothered.

The NE Essex CCG HF Chairperson was aggressively hostile to any such publication being linked to the HF, and the CCG was uncomfortable with the possibility of the text exposing employees to some sort of legal challenge. A challenge about what?

Everything in the article was already in the public domain. It would appear that the official bodies did not like criticism and the possible implication of incompetence. In spite of that, a verbal presentation was given to a dozen members of the public who were attending a surgery Patient Participation Group meeting. They gave the impression of being quite appreciative. Was Colchester's cancer experience a one-off? No!

On 5th February West Herts Hospital Trust's Cancer Unit was exposed for having inappropriately removed a large number of patients from their waiting lists. There was no admission of motivation, but the most likely reason was to achieve targets and avoid penalties. This is a very simple ploy to delude the whip crackers at Monitor, and is probably endemic in the NHS.

Preventable hospital deaths

In 2013 Bruce Keogh sent teams of investigators to 14 Hospital Trusts which were considered to have exceptionally high death rates as judged by the Summary Hospital Mortality Index (SHMI). CHUFT was one of those hospitals. This was an excuse for the CQC to ferret about through doors which the hospital would have preferred to have kept closed. The public wasn't interested in the actual number of deaths, but the number of deaths that could have been prevented!

The report, published in July 2013, identified areas of poor inpatient management which could have contributed to these adverse events, but the review team did not have the resources to determine how many of the 1,400 deaths could have been prevented.

At a public meeting held at the headquarters of the local CCG in August 2013, CHUFT's Chief Executive claimed that 5% of the recorded deaths were deemed to have been preventable. When questioned about how this figure had been obtained, all he could offer was that about half of the deaths had been reviewed.

Further probing revealed that death audit meetings were conducted routinely every Friday from 07.30 to 09.00, and that the case notes of 6-8 patients were usually reviewed.

If one assumes that 8 patients were reviewed at each meeting and all Fridays, including bank holidays, were used, that would mean that 424 case notes (not 700) were examined in 79½ hours; i.e. each review took an average of less than 12 minutes!

In the Preventable Incidents Survival and Mortality (PRISM) study, which looked at 1,000 case notes of randomly selected deaths at 20 Hospital Trusts, 5.2% of deaths were judged to have been preventable. A conservative estimate of the average time taken to assess each of their allotted 50 case notes, by two of PRISM's experienced investigators, was about 40 minutes. This gives room to doubt the accuracy or thoroughness of in-house death audits. If the Government is so obsessed by hospital death rates it needs to come up with something that is a bit more credible, than this type of CQC task force.

The pathology shambles

Eric Watts describes how the Hospital Laboratory service is being broken up for the wrong reasons and for the benefit of the Private Sector. CCGs are actively involved in this process and are not keeping patients informed about the disadvantages of this devious arrangement. Eric's essay is a sequel to Malila's article in the December 2010 Newsletter. This saga continues to run. There may be many more twists in this tale before it is done.

Risking the benefits of wisdom

Peter Trewby takes a critical look at how we have been persuaded to believe what we are told is "best practice" – but not necessarily for the patient. The development of regional specialist services is often orchestrated by aspiring academics or by those working in specialties which rely heavily on sponsorship from the pharmaceutical industry. As a result, new procedures can become embedded in NICE guidelines empowering patients to seek compensation if these guidelines are not adhered to. Maybe patients should be encouraged to seek redress when their Nice Treatment causes harm.

Recapitulation is essential

Jacky Davis reminds us of the nine most important myths promulgated by the detractors of the NHS. Frequent repetition is vital. That is how messages become embedded.

The convoluted patient Journey

Whole forests of trees have been felled to provide the paper to argue the hind legs off this particular donkey. Fifty years ago it was simple. Your GP provided a 24/7 service for almost everything other than serious or life threatening events. The local hospital dealt with everything else apart from highly specialised problems which were referred on to a Teaching Hospital. Today that strong link between primary and secondary care has been broken, with your GP either unwilling or unable to provide a 24/7 service. That gap has been filled by private contractors, with a 111 service giving verbal advice, and an "Out of Hours" service offering some hands on advice. Neither of these private services has the depth of knowledge or experience of your GP, and run the risk of giving you inappropriate advice or referring you unnecessarily to hospital. At the same time the hospital is expected to have Consultants on site 24/7.

The CCG which commissions and pays for services at our local hospital wants to reduce patient access to hospital in order to save money, but the CCG doesn't hold the GP budget and therefore cannot increase patient access to their GP, except by paying for Locally Enhanced Services, which are themselves about to be put out to tender. Straight out of the Politicians' **Divide and Rule** handbook!

CCGs and the Private Sector

Over the next three years the Government have set all sectors of the NHS the task of improving care for an increasing number of patients but with 20% less spending power. This healthcare miracle, feeding 5,000 with only five loaves and two fishes, is about to be re-enacted but feeding 6,000 with two fishes and 20% less bread. Clearly elementary arithmetic isn't something that Eton boys excel at! Maybe the Bishops in the Lords should be apprised of this situation? Maybe not. After all, they believe in miracles!

The assumption of the politicians is that the NHS is inefficient and wastes 20% of its resources. Since about 70% of healthcare is delivered by the doctors, nurses and allied healthcare workers, the inference is that this group of dedicated personnel are slacking 20% of the time! Therefore in order to get more out of these vilified, downtrodden individuals, the Government has set up a complex series of whip-masters, who are themselves almost totally unregulated, to chastise these underperforming health workers!

The NE Essex CCG has had no alternative other than to buy into this nonsense, but with 70% fewer staff to do the commissioning than the PCT which it replaced. The solution has been to start amalgamating their

200 or so contracts into just a handful of overarching services which bundle together smaller services to form large complex business cases. However, without the resources to manage such contracts, the plan has been to open the doors to competition. Clearly that exposes the NHS to the cash rich compassion poor private sector.

In the next financial year our CCG's Director of Finance will have to find £20m of savings. This can only be achieved by having very tight **fiscal** Key Performance Indicators (KPIs) underpinning every contract! The role of the doctors involved in formulating these contracts is to make them robust enough not to allow the provider the wriggle room to default on the **clinical** KPIs and avoid financial penalties, but at the same time enough scope for the provider to make a reasonable profit, otherwise the market would not bid.

We have had recent experience of interested parties withdrawing from the bidding process because the forecast for profits was too small. Failure to engage with the market would leave CCGs still holding the baby, but without the means of achieving that current annual 5% cost reduction. In that situation services would either have to be cut or rationed in order to avoid the CCG going bankrupt!

If fiscal KPIs are so important to NHS England, why does it not ask NHS Scotland to take over its services? After all, NHS Scotland has achieved the same waiting list reductions as England, but without the massive increases in outpatient, inpatient and A&E activity which has been fuelled by the introduction of Payment by Results in England.

Of course, under the present legislation, NHS England would not be able to do that without also opening up the bidding process to the whole of the multinational private healthcare industry! And what underpins these private profiteers? The banks!

Every recession and banking crisis in the last century has been caused by the unregulated activity of the banks, including the bank-rolling of the combatants involved in the Great War. Our Treasury is too addicted to the supply of golden eggs from the city's gambling goose to get involved in curbing its appetite for unhealthy investments. When the goose goes tits up, it's the people who elected these sleazy politicians who pay the price for putting her back on her feet. That is how the NHS has been saddled with a £20bn reduction of its budget to meet the increasing healthcare needs of the population.

Latest news reveals that Stuart Rose, (ex M&S boss, who is joined at the hip to Bridgepoint Capital, which owns 80% of Care UK), has been recruited by Jeremy Hunt to "sort out" the NHS! There's a surprise! *This is why the 2012 Healthcare Act needs to be overturned or seriously modified.*

MARK AITKEN
Guest Editor

Proposed Review of the NHSCA Constitution

A special meeting of the Executive Committee was held on the 13th February 2014 with the objective of defining what changes, if any, were required to strengthen the Association and boost its standing.

Ten EC members were able to attend despite widespread problems with travel. Written submissions were received from several EC members who were unable to attend. The following changes were proposed.

Membership

At present, standard membership is open to consultants and associate specialists, and associate membership is open to specialist registrars. Many GPs and junior doctors share our views but do not have a comparable organisation. It was agreed that widening the membership to include like-minded GPs and junior medical staff would build up and strengthen the Association. This would obviously mean a change of title.

Title

Several alternatives were aired. The title of "DOCTORS FOR THE NHS" was thought to be appropriate.

Recruitment

Current membership stands at around 700. Membership numbers have been increasing slowly but the rate of recruitment needs to be stepped up given the current threats faced by the NHS.

Postal recruitment: At present this entails circulating all consultants in a Trust/hospital at the rate of one hospital per week which amounts to about 150 letters per week. Each hospital is covered every five years.

Targeted recruitment, which has a higher success rate, is directed at consultants identified in the media and letters pages of journals and personal contacts of EC members. Postal recruitment is time consuming and is at present undertaken exclusively by Peter Fisher.

Social Media: It was felt that this was the most

effective way of communicating with doctors with an active interest in current issues. It would require a regular commitment from several members but this should not be onerous.

Media links: Articles in medical media such as the BMA newsletter, Pulse, Hospital Doctor etc. could publicise the association and its re-launch and carry a link to the website.

Please would those of you using Twitter comment on this.

Website

It was agreed that a website which was striking and easy to navigate was crucial. Professional input from a website designer may be worthwhile. A clear specification of the style and content best suited to the association is a prerequisite.

Please visit the NHSCA website and submit your views/suggestions.

In making this change to membership and title of the Association there are a number of practical issues which are being investigated.

Meanwhile your Executive Committee needs to have your views on what is being planned to enable our Association to have the greatest possible influence in the ongoing struggle to preserve the essential principles of our NHS.

The next Committee Meeting is on 20th March so we would be grateful to have your comments before then if at all possible. Please reply to malilanoone@gmail.com

MALILA NOONE

Confessions of a Whistleblower

If you blow the whistle you are likely to be called courageous or foolhardy. Either way the aspiration is that there will be change for the better, but this is not necessarily the case. My first experience has made me a little more cautious and less optimistic, but it hasn't dissuaded me from putting my head above the parapet.

In 1966, when I was working as a Medical Registrar at Mile End Hospital, I found myself one Saturday afternoon torn between exposing a pernicious practice or just shrugging my shoulders and mumbling, "C'est la vie".

At the time there were two medical teams working a 1:2 rota. When our team had the weekend off we would be on call on the Friday and would spend Saturday mornings tying up the loose ends. The other team invariably sloped off early on Saturdays leaving some of their Friday night problems unresolved. This situation was exacerbated by a longstanding conflict between the two Consultant Physicians whose gibes provided both concern and amusement for the junior staff.

On this particular Saturday afternoon I was called by the Sister from one of the other Consultant's wards to countersign a verbal prescription for Morphine which the night nurse had administered on the instruction of the duty PRHO. The Sister added, "By the way, the patient isn't looking too good".

Rather nonplussed, I went to the ward to find that the patient in question was not only looking grey, sweaty and gasping for breath, but also he had not been clerked, let alone examined, by the duty doctor.

After addressing the lack of documentation and arranging an appropriate management plan, I was foolish enough to write a short paragraph in the patient's case notes berating this Junior Doctor's aptitude and her Consultant for condoning her lack of clinical responsibility. Maybe, in the true sense of the word, this was not whistleblowing, but I had written something in an official document, which, if untrue, might

be construed as defamatory.

On the following Monday I found my boss greatly amused by this exploit. For him it was but another notch on his tally stick. However, late that afternoon I was summoned to the other Consultant's office and was given one almighty bollocking for impugning his integrity. Furthermore, I was told in no uncertain terms, that were I to apply for another job in London, he would caution the interview committee against my appointment. A subsequent visit to the Postgraduate Medical Federation offered me little reassurance that his threats would not be carried out.

After many abortive attempts to secure a Registrar post in a London teaching hospital, I successfully applied for a Medical Registrar's post at one of the teaching hospitals in Glasgow. In hindsight that was my best career move, and my nemesis had been outsmarted. But what of those Friday night admissions back at Mile End? A girlfriend kept me in the loop. Sadly nothing changed for the better.

Plus ça change, plus c'est la même chose!

MARK AITKEN

Ode to Whistleblowers

Blow the whistle, blow it loud.

Castigate the silent crowd;

Those sycophants that have no shame

Who pounce around and blithely claim

That all is well, when all is not

And salve their souls without a blot.

Inter these fools, don't wave the shroud,

And blow your whistles clear and proud.

The Outsourcing of Pathology Services

Hospital practice relies heavily on its laboratories to diagnose and monitor patient management. Forty years ago a single Consultant Pathologist could oversee all the various laboratory disciplines and lab technicians were multi-skilled, whereas today each sub-specialty requires at least one Consultant and its own on-call technicians to keep the wheels turning. Fortunately the escalating cost of providing the hospital service could be offset by the income generated from the ever increasing numbers of GP requests.

The Carter Review recommended that hospital laboratories serving small local communities should cooperate with other hospitals to form larger consortia. The most cost effective solution appeared to be one that involved populations of between 500,000 and 1,000,000. However the East of England SHA decided to encourage PCTs to form much larger groups and create Hub Megalabs, ignoring the adverse effect that would have on the service to patients living furthest from the Hub laboratory.

It did not take the private sector long to realise that there would be money to be made if they could siphon off the low cost profitable GP work. Accordingly the Carter Review was used to justify the removal of all non-urgent laboratory work from the hospital and GP generated work, leaving the hospital to pick up the expensive commercially unattractive portion.

It was assumed that a GP blood test would be unlikely to reveal life threatening results. That is not true.

We regularly find unexplained anaemia, neutropenia and thrombocytopenia necessitating urgent hospital admission. Furthermore, what these money grabbing bureaucrats ignored was the risk to patients caused by samples having to be transported over long distances to laboratories lacking local knowledge. The measurement of blood electrolytes is distance sensitive. Potassium levels in the serum rise proportionately with time from venesection to testing. Consequently the sample from a patient with life-threatening hypokalaemia might become "normalised" and generate inappropriate reassurance, whereas

a sample from a normokalaemic patient might become artificially "hyperkalaemic" and generate an inappropriate hospital admission. The first patient might die and the second patient could add a cost pressure to the CCG.

I will illustrate this dilemma with a patient from Basildon on whom his GP had sent a non-urgent blood sample, taken at noon on a Thursday, to investigate "tiredness". The results became available at 3.0pm that afternoon and revealed a blood glucose of 35mmol/l. The lab staff phoned the surgery, were told by the answering service that the surgery was closed and that they must phone back in the morning (many GPs take Thursday afternoons off). Clearly the GP had not expected such a degree of abnormality. No telephone number was available and searching the hospital Patient Administration System database did not identify the patient, but it did show a patient with the same surname at the same address and therefore I was able to telephone his house. His wife answered and advised that he was now asleep and it was difficult to rouse him. This suggested rapidly progressive diabetic pre-coma requiring immediate urgent treatment. I arranged his admission straight away.

According to the planned reorganization of services this patient's blood sample would have had to have been sent to the Hub Megalab in Bedford more than 90 miles away. If that had been the case it is unlikely that the result would have been available during normal working hours, so we can only speculate on what might have happened given the reduced levels of senior staff in highly automated Megalabs, and I doubt whether the lab personnel there would have been able to assess the clinical situation and/or arrange a speedy admission.

It is bizarre that the local labs were not offered the contract, but that appears to be because the winning bid was said to be 'better', i.e. they did a better job of selling their services possibly because they have partners, including SERCO, who are experienced in marketing, whereas local labs are simply inexperienced at salesmanship. As a result, the local CCG, appreciating the dangers and mindful of the opposition expertly publicised in the Southend Echo, decided not to

proceed and they are currently trying to broker a local solution. Other CCGs are in similar situations but still trying to negotiate with the proponents of this costly waste of public money. So far three controversial regional pathology reorganisations have incurred £2m in central costs and experts estimate the total bill for NHS trusts and bidders to be about £10m and rising.

A freedom of information request revealed that during 2011-12 and 2012-13 nearly £900,000 was spent on central "legal/financial costs", £874,000 on "contractor/consultancy SME costs", £268,000 on central "staff pay costs", £4,600 on "software" and £1,400 on "conferences".

In September 2013 the West Midlands

procurement process was abandoned because commissioners did not believe it would deliver the, "clinical and financial benefits", previously anticipated. In the meantime the East Midlands tender process is currently subject to an on-going Office of Fair Trading enquiry.

These nefarious privatisation negotiations have had a demoralising effect on existing hospital laboratory staff. Many Hospital Trusts have already issued 90 day termination of employment notices, hoping that staff would find other jobs before the hospital became liable to pay for redundancy.

ERIC WATTS

Colchester's Cancer Crisis

After NHS England published their report* on Colchester's Cancer Services on 19th December 2013, the hospital published their intentions to carry out the necessary remedial actions, and the CCG enunciated their determination to oversee these changes. However, neither of these Press Releases revealed why the hospital was not keeping pace with demand nor how these deficiencies had been allowed to develop.

The last 36 pages (appendix 6) of this 187 page report, reveals how staff struggled to keep pace with demand. This part of the study was performed by an external Intensive Support Team (IST) which conducted a series of visits, meetings and interviews with 102 named members of staff. The vast majority of the interviewees were working at the clinical coalface, although there were no details of who had actually said what. This process might be described as officially sponsored whistleblowing. The overarching conclusion of the report was that for the most part staff, dealing with cancer patients at the hospital, delivered an excellent service, but that parts of that service were flagging as a result of underfunding. However, before one can appreciate the significance of this information, one needs to look at how cancer services have evolved over the past decade.

The diagnosis and treatment of cancer has

become increasingly complex and complicated by a large number of ground-breaking methods of investigation and an array of different treatment regimens. Also the cancer spectrum had been fragmented into over a dozen different but interrelated disciplines and areas of expertise, which included other hospitals in East Anglia and London. As a result of this fragmentation Multi-Disciplinary Team (MDT) Coordinators were required to oversee the patient journey, and pull together the threads of the necessary lines of investigation so that critical nationally set targets could be met expeditiously. The process also required the assistance of empathetic Clinical Nurse Specialists and other care workers to help patients with difficult decision making, and most importantly, compassion.

Additionally there is the Government's cancer awareness agenda which in some specialities has increased the workload fourfold, and yet no additional resources have been given by central government to meet this extra demand.

As information on each patient's investigative pathway is accrued, Data Entry Clerks (DECs) feed this into the system to help the MDT in their crucial decision making assessment, but herein lies the nub of the problem. The work of a DEC is repetitive, mind-numbingly soul-destroying, and unless these low paid employees have

frequent breaks and a friendly supportive environment in which to deliver their service, errors will begin to creep in. At the hospital this problem was compounded by having to work with a clunky archaic electronic Patient Administration System (PAS), a variety of separate data bases which did not communicate with each other, and a collection of disparate faxes and pieces of paper inconsistently floating about their departments.

The IST found that cross checking of data was not routinely carried out and as a result some gross errors, from the recording of dates to the double entry of patients, went by uncorrected and time critical targets were breached. Unfortunately root cause analysis of these breaches was patchy with many patients falling off the radar and then being lost to follow-up. There were also problems outside the control of the hospital. Communications with the Regional Neurosurgical Centre at Queens Hospital in Romford, to which patients with brain and spinal tumours were referred, was at times rather poor. A number of London Teaching Hospitals exchanged and referred on patients, without feeding back the information to Colchester. Ipswich Hospital, to which patients with gynaecological cancer were

referred, appeared to lack the capacity to deal with the workload and that meant that patients often received unnecessary additional courses of pre-operative chemotherapy.

The IST found that staff shortages and poor infrastructure had been identified by the various cancer teams, but their requests for additional resources were largely ignored. One team complained that they had their carefully considered business case for more staff and resources repeatedly turned down by the Board. In spite of all these handicaps with which staff had to contend, most of the time they still delivered an excellent service to their cancer patients.

At the hospital's public Board meeting on 16th January 2014, the Chairman claimed that she knew nothing about the pressures on their Cancer Services prior to the Care Quality Commission's inspection in August 2013. That is hard to believe.

**www.england.nhs.uk/wp-content/uploads/2013/12/canc-serv-chuft-1.pdf*

MARK AITKEN

BMA

COUNCIL ELECTIONS

Candidates for these elections have now been announced.

They include three NHSCA members: -

Jacky Davis

Allyson Pollock

Kevin O'Kane

Candidates in other branches of the profession who are supportive of our views include:-

David Wrigley GP

Gurdave Gill GP

Beth Banks Medical Student

Letters to the Editor

Appointment criteria for NHS Managers.

There are currently a number of instances where Chief Executive Officers and other highly paid managers in NHS who are found to have failed to follow the Nolan Principles of behaviour in Public Life. Once found out and exposed such people should be 100% barred from further employment in the NHS.

What are the criteria for selecting these officers? The criteria appear to be either flouted or to be inadequate in themselves. Who polices the application of employment instructions?

No one employed in the NHS should be paid more than 10 times the pay of the lowest paid per whole time equivalent. If the person is not motivated to work for, say, up to £120,000 a year then they are not the sort of motivated and principled person needed by the NHS.

Chris Burns-Cox

Dare to be Wise

“Dare to know” (*Sapere aude*) was coined first by the Roman poet Horace (65-8 BC) and used by the philosopher Immanuel Kant as the defining phrase of the enlightenment. It carries hints if not of rebellion at least of autonomous thinking and so fits awkwardly with the encouraged conformity of modern medical practice. *Sapere* also means, be wise: *sapere aude* – “Dare to be wise”. To know and to fully understand what we know, and to tell as well. It is a fitting phrase that encapsulates so many triumphs of past medical research: Semmelweis on puerperal sepsis, Snow on the spread of cholera, Marshall and Warren on *H Pylori*. They dared to know, to be wise and to tell, and in so doing changed the course of medical practice.

But what of today’s evidence based medical practice based so much on the results of large clinical trials? Is there a need for even greater wisdom here? To extrapolate large controlled trials some containing thousands of patients for the benefit of the individual in front of us requires a numerical literacy that few of us, let alone our patients possess. Archibald Cochrane, the doyen of evidence based medicine, wanted three questions asked of any intervention: can it work; does it work; and is it worth it? The first two questions are answered definitively by the science and the clinical trial; but the third? We stumble so often at the “is it worth it?” And because it’s a tough one, it’s seldom asked and because it isn’t asked we are in no position to rebut the enthusiast or inform the patient. To answer it we need knowledge of the absolute risk reduction of the intervention, the type and frequency of the collateral damage, the patient’s preference, and the cost of the intervention, and the last can’t be judged in isolation because in today’s cash limited NHS one patient’s gain from an expensive treatment or preventive strategy comes at another’s loss.

Take fibrinolysis for acute stroke. The perceived essential need for fibrinolysis in the management of stroke has been the driving force for centralisation of stroke services. The immediate collateral damage (or opportunity cost depending on one’s point of view) is that elderly patients are cared for and die far from home. Also local hospital staff become de-skilled

at managing stroke patients so when stroke patients do end up in the local hospital their treatment will be less than ideal.

Do the medical benefits trump the disadvantages? In the NIND study, the use of fibrinolysis in the 15% or so of stroke patients for whom it was appropriate, resulted in a 13% absolute increase in the rate of full recovery (39% in the treatment group v 26% in the placebo group). But this came at the price of a 5.8% increase in symptomatic intracranial haemorrhage in the treatment group within 36 hours of treatment. There was no survival benefit at one year but there was an excess mortality from intracranial haemorrhage at 36 hours of 2.6% in the treatment group. Forty-four suffer a symptomatic intracranial haemorrhage within 36 hours of treatment and 20 die acutely for every 100 that make a complete recovery and there is a 20 – 38% chance (depending on the score used) that the patient who died would have otherwise made a complete recovery had they not had fibrinolysis. It’s a close call; but put into the equation the appointment of extra stroke physicians to man 24 hour on call rotas and the movement of patients and closure of peripheral beds we must question whether we can or should have implemented the strategy in the first place and certainly whether we can afford it.

The much trumpeted centralisation of stroke care in London has been administratively very successful, albeit at a cost of £20 million,² but how has it been for the patient? It’s difficult to be certain as no controlled trial is possible and survival figures were improving anyway before implementation but best possible modelling shows a 1.5% reduction in mortality at 90 days with survival improving from 87.2% (95% CI 86.7%–88.7%) before implementation to 88.7% (95% CI 88.6%–88.8%) after.³ We should applaud the zeal of the enthusiasts but question their wisdom in imposing such a blanket recommendation for such a modest result especially with knowledge of the number that die or are injured as a direct result of the intervention. Surely there should have been more discussion with the public whose passion for local treatment and local hospitals often matches the zeal of the medical enthusiast and

might well surpass it if these modest and slightly alarming figures were shared dispassionately with them.

Similar, but marginally less compelling, are the arguments for and against intervention in acute myocardial infarction. The 1998 ISIS 2 study showed, when compared to aspirin, fibrinolysis reduced the 5 week mortality from 11.8% to 9.2% (1988 ISIS 2), a 2.6% benefit (97.4% did not benefit) and a small 0.4% percentage increase in major bleeding. The numbers harmed are small but the numbers that benefit are also small. It is the ratio that matters: 14 patients will have a major bleed (and some die) so 100 can benefit. PCI results in a further 2.0% reduction in mortality but at the expense of huge increases in the number of highly specialised cardiologists, paramedical staff, equipment and transport necessary for 24/7 PCI, which will inevitable result in fewer resources for the equally pressing needs of primary care, elderly care and preventive medicine.

The imperative for centralising cardiac and stroke services is the most quoted reason for closing or downgrading peripheral hospitals much to the distress of local patients to whom these very marginal medical benefits are seldom if ever presented and if they are only in terms of relative, not absolute, risk reduction.

Perhaps one reason the figures are not presented is the difficulty in expressing the risk/benefit ratio. For some strategies, such as compulsory wearing of seat belts or childhood vaccination, the risk is imperceptibly small but for others such as aspirin in the prevention of cardiovascular disease or use of warfarin in atrial fibrillation the risk is significant and, using data from controlled trials, quantifiable. Most medical measures benefit only a small percentage of those treated, so most of those harmed would never suffer from the condition for which the intervention was designed. We know the percentage (but not the individuals) that will be harmed, and to adopt the intervention we must tacitly agree that the number harmed is an acceptable trade-off for the population's gain. Without loss there can be no gain. We need to understand this, be frank about it with ourselves and our patients, know the figures and develop an internal yardstick of what is and is not an acceptable risk. The table shows the number harmed for 100 to benefit for a number of commonly used preventive and

treatment strategies. Patients will rank different harms and benefits according to their experience and prejudices, and so will we. But once the patient has been properly informed it should be their wish, not ours, that becomes the focus of our conversations with them.

Some of the figures are striking (see table): 4 carotid endarterectomy following a TIA causes 25 perioperative strokes or deaths for every 100 patients rendered stroke free at 5 years; warfarin for atrial fibrillation in patients less than 65 years old results in 400 having an intracerebral haemorrhage for every 100 patients prevented from having a Thromboembolic Event (TE); aspirin, even in patients at high risk of cardiovascular disease, causes 33 major bleeds for every 100 prevented from having a vascular event; thromboprophylaxis in hospital patents causes 133 to bleed for every 100 prevented from having a pulmonary embolism and for breast cancer screening, 1,000 patients have unnecessary cancer treatment and 20,000 are at risk of psychological distress because of an initial false diagnosis for every 100 cancer deaths prevented.

Few doctors let alone patients know how close harm is to benefit. If we were honest with ourselves let alone the patient so many of our treatments would fall at the "is it worth it?" third rung on the Cochrane ladder. Statins, warfarin, aspirin, beta-blockers, antihypertensive drugs all score under 1% absolute risk reduction per year, a level at which only a quarter of patients says they would be prepared to take a preventive drug⁵ and yet GP's practice income is partially dependant on the number persuaded to take these drugs. The benefit to the population trumps all other consideration even though it is the individual patient not the population that must take the drug and it is the individual not the population who is exposed to its side effects.

Coming back to centralisation of services; is it not time to rein back from the mantra that centralising services will give such benefit to the community that local hospitals with all the benefit they bring to the neighbouring population and the loyalty they engender in their staff should be downgraded or close, and should we not temper the drive of well-meaning enthusiastic super-specialists with a more holistic approach to patient care? Post graduate medical education will need

Table

Number of subjects **H**armed for every 100 that **B**enefit from different interventions.

INTERVENTION	Harm to the individual	Benefit to the population	Harm/Benefit
Carotid endarterectomy for TIA	Postoperative stroke or death	Stroke free at five years	25/100
Warfarin for AF age < 65	Intracerebral haemorrhage	Thrombo-Embolism (TE) prevention	400/100
Warfarin for AF age 65 - 74	Intracerebral haemorrhage	Thrombo-Embolism (TE) prevention	54/100
Fibrinolytic therapy for acute stroke	Death in first 36 hours	Minimal or no disability at 3 months	20/100
	Symptomatic intracranial bleed	Minimal or no disability at 3 months	44/100
Continuing aspirin in high risk patients	Major extracranial bleed	Prevention of non-fatal MI	25/100
Statins (all trials)	All adverse effects	Prevention of cardiovascular event	24/100
	Development of diabetes	Prevention of cardiovascular event	11/100
Venous TE prophylaxis in hospital inpatients	Major bleeding	Pulmonary embolism prevention	133/100
Colorectal cancer screening	Side effects of colonoscopy	Colorectal cancer death prevention	10/100
Breast cancer screening	Unnecessary cancer treatment	Breast cancer death prevention	1,000/100
	Mental harm from false diagnosis	Breast cancer death prevention	20,000/100

to be refashioned to promote the generalist over the specialist, but this surely is a worthwhile aim for clinical and cost containment reasons and is a goal the Royal College of Physicians has already started to pursue. Is it not time to engage more with the local population and to share the facts and figures and to move away from paternalism and hegemony, and should we really be closing hospitals when recent evidence suggests we already have far fewer than the OECD average per million population?⁶ Is it time to inform our political and medical masters that the hospitals do not actually belong to them anyway, nor indeed to the “NHS”, but to the local population which funds them through taxes and whose predecessors endowed them through subscription and legacy? Is it time to move away from the “we must...” unless the “we” refers to the population that we purport to serve. Is it not time for us all, and especially the medical profession to, “dare to be wise”?

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References

1. The NINDS rt-PA Stroke Study Group. Tissue plasminogen activator for acute ischemic stroke. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. *N Engl J Med.* 1995; 333:1581–87.
2. <http://www.implementationscience.com/content/8/1/5>
3. <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0070420>ISIS 2. *Lancet* 1988; 332: 349 – 360.
4. Trewby P. Number needed to sacrifice: statistical taboo or decision-making tool? *JRSM Short Rep.* 2013 Mar; 4(3):22. doi: 10.1177/2042533313476684.
5. Trewby PN, Reddy AV, Trewby CS, Ashton VJ, Brennan G, Inglis J. Are preventive drugs preventive enough? A study of patients' expectation of benefit from preventive drugs. *Clin Med.* 2002 Nov-Dec; 2(6):527-33.
6. Appleby J. Do we have too few hospitals? *BMJ* 2014;348: 20-21

The Myths About the NHS

1. We can't afford the NHS

International studies have consistently shown the NHS to be one of the most cost-effective health services in the world. A recent Commonwealth Fund study showed that the UK saves more lives for each pound spent, as a proportion of national wealth, than any other country looked at apart from Ireland. Among the 17 countries considered, the US healthcare system was among the least efficient and effective.

2. 'Health tourism' is bankrupting the system

The most reliable figures suggest that unrecovered costs from treating foreign nationals account for less than 0.2 per cent of the NHS budget. The government has encouraged scaremongering as a useful distraction from the real problem of £20 billion in cuts to the service.

3. The government has no intention of privatising the NHS

Politicians assure us that the NHS will remain 'free at the point of delivery', but one tenth of surgeries are now privately owned, and contracts worth millions of pounds have been given to the likes of Virgin and Serco. Because contractors may go on using the trusted and familiar NHS logo, patients may not even know they're receiving treatment from a private company.

These claims also assume that how we pay for our health care is the only thing that matters. The population values the public service ethos that has traditionally underpinned the NHS. Polls show that the majority of people want local and national government to run public services, and only consider contracting out if this fails. People also want accountable health care, while private contracts hide behind 'commercial confidentiality'. The chair of the House of Commons public accounts committee, Margaret Hodge, says that even she can't break through their wall of secrecy.

4. Private companies will deliver a cheaper and more efficient NHS

There is not a scrap of evidence that the price

goes down and efficiency increases when private companies deliver NHS care. In fact, the evidence points the other way. Costs increase and services may well get worse. The fiasco of hospital cleaning has shown the reality of privatisation: apparent short-term savings, but at the expense of lower hygiene standards, higher rates of hospital-acquired infection, the break-up of established ward teams and a casual workforce.

Already we have seen major companies such as Serco criticised for failing to report accurately on their performance. Recently an NHS contract for elective services with the private company Clinicienta was terminated due to poor quality care. It has been bought out at great expense to the taxpayer and taken back in-house by the NHS.

5. The government's reforms are aimed at cutting bureaucracy

The Health and Social Care Act was never about cutting bureaucracy, though that argument helped to get Lib Dems on board and push the massive bill through parliament. Today we have a bigger bureaucracy that consumes more time and resources. The 150 primary care trusts have morphed into 211 'Clinical Commissioning Groups' (CCGs). Most of the CCGs' work is outsourced to 'Clinical Support Units' (CSUs), to be performed by people the NHS does not call employees, and who are not subject to the Freedom of Information Act. By 2016 all these services could have been put out to competitive tender.

CCGs and CSUs are monitored by a new national bureaucracy, NHS England, which has 27 local area teams that don't meet publicly or publish papers. Among the other tiers of bureaucracy are the Health and Wellbeing Boards, Healthwatch England, toothless local Healthwatch patient groups (which are forbidden to conduct any 'political' campaigning), citizens' panels, clinical senates, Patient Participation Groups (PPGs) attached to each GP practice and funded by the local CCG, etc., etc. The difference is that the new bureaucracy is less accountable.

6. The reforms will save money

The NHS is now less cost effective. Money is being wasted on turning hospitals into a market, in which they have to compete rather than cooperate and GPs are legally required to spend money on expensive and lengthy tendering processes. The proportion of the NHS's budget spent on administration has increased dramatically, rising from around 6 per cent to around 15 per cent (the government won't tell us exactly how much). An increase of this size represents about £10 billion. Another £54 billion has been spent on PFI projects that will eventually cost taxpayers an estimated £300 billion. Meanwhile, the NHS has suffered rationing, bed closures and staff cuts over the past two years. If we abandoned costly and unnecessary privatisation schemes, we would save billions for frontline care.

7. The reforms will give patients more choice

Patients have less choice now than they did 20 years ago, when a GP could send a patient to see any provider. Many GPs are now given targets to lower their referrals to hospital. Referrals may pass through a management centre where they are checked and may be redirected by people with little or no clinical training and no knowledge of the patient. One in eight referrals is rejected altogether. Operations once available from the NHS, such as joint replacements and hernia repairs, are increasingly being rationed or withdrawn.

Market 'competition' is unlikely to result in diversity. Large companies have the resources to enter expensive tendering processes for NHS contracts, crowding out NHS workers and small social enterprises. Between April and August 2013, 16 major NHS contracts went to the private sector and two to NHS providers. If this continues we face the possibility of quasi-monopoly private providers, which may have more talent for winning contracts than for running clinical services. The private sector also has no obligation to provide a full range of services, so it tends to pick the ones it sees as profitable. Any replacement of local NHS providers by private companies can result in reduced services and gaps in care for vulnerable patients.

8. The reforms put GPs in charge

Polls show 73 per cent of GPs now believe they have been set up to take the blame for rationing health care. Far from being in charge, GPs will effectively be rubber stamping decisions imposed by NHS England and CSUs. Only a third of GPs are actively involved with the work of CCGs, and of those who are involved, more than a third have links with or shares in private medical companies and insurers.

9. The reforms give power to local people

Local consultations have been consultations in name only. Petitions with thousands of signatures have been ignored. After Lewisham's local hospital was sacrificed – to bail out a nearby trust crippled by a massive PFI debt – community members had to take Jeremy Hunt to court to overturn the decision. Ministers have said they'll appeal, or change the law if necessary to give themselves new powers, making their willingness to go against local people entirely transparent.

The English NHS is under attack as never before, with the government briefing against it at every opportunity and aggressively pushing a privatisation agenda. But the NHS wasn't broken and didn't need fixing. When the Labour government left office, the NHS had its highest ever popularity ratings. After investment in the service, waiting lists had come down and outcomes were improving rapidly. There was every reason to believe that a public, accountable NHS could continue to evolve, improve and meet the challenges of the future, including care for an ageing population.

JACKY DAVIS

Book Review

Cancel The Apocalypse: The New Path to Prosperity

Andrew Simms



Andrew Simms, the author of the best-seller *Tescopoly*, has a new book out that I feel sure will be another best-seller. Its title is, *Cancel The Apocalypse: The New Path to Prosperity*. It is a remarkable book for a number of reasons. For a start, *Cancel The Apocalypse* (CTA) is a very long book (409 pages of text excluding pages of useful notes and references) but it is an easy and pleasant book to read because Simms eschews jargon despite the subject matter being focused on economics. The book is long because the author has a lot to say. It is a book to keep – and loan.

Simms is a Green or 'new' economist based in a British think-tank of international repute, the *new economics foundation* (*nef*). CTA is intriguing because it brings new insights and information to an exceedingly important but normally tedious subject – what ex-president Clinton memorably described as *the economy, stupid!*

The late EF (Fritz) Schumacher is perhaps the best-known Green economist but the Green MP Caroline Lucas is fast becoming well-known and respected. The insights of CTA reflect well *nef* and other new or Green economists.

What is the thesis of CTA? The subtitle is a very good guide – *The New Path to Prosperity*. Normally a book's Contents reveal a lot and the 11 chapters get reasonable space. However, I confess that I didn't get much from my first examination of the Contents. In contrast, after reading the book, I found the Contents a useful summary.

Like other Green economists, Simms draws attention to the inadequacies of key economic concepts and indicators, particularly those for progress or 'growth', such as GDP and GNP. He discusses several of the blind alleys that we end up in if we aren't awake. Simms covers a lot of ground and I will mention only a few specific topics to flesh out this brief review. As one might

expect, money and banks get thorough and interesting discussions. But the range of subjects covered is wide and includes, for example, organic agriculture - which is advocated for small farmers in poor countries. Research has produced some encouraging results.

Simms is far from being utopian – he is no dreamer in an increasingly chaotic world. His stance is worth quoting in detail:

"No inevitability attaches to the replacement of a flawed and failing economic model with a better one. I do not think it will recognise its own mistakes and retire to be replaced. There is every chance that, like the financial markets, it will follow its nose short-sightedly over a cliff and drag the rest of us along behind it, all the while blaming everyone else for the rush of passing air and fast-approaching rocky valley floor. All of the enormous potential ... will only come to pass if we choose to act. Many already are. However, there needs to be a majority, or at least a critical mass. I am hopeful."

Simms expands this stance by quoting from *Hope in the dark: the untold history of people power* by Rebecca Solnit:

"...To hope is to give yourself to the future, and that commitment to the future makes the present inhabitable. Anything could happen, and whether we act or not has everything to do with it."

The overall experience of reading CTA is very positive. One picks up masses of relevant information and is encouraged by useful insights and concepts. It would make an attractive present for the inquiring reader who wants to pick up a good understanding of Green social and economic perspectives. I tried it on my son and daughter.

PETER DRAPER

The AGM and Conference 2014

will be held on Saturday 4th October in
London

The precise venue has not yet been finalised but will be in central London.
There will be further details in the June Newsletter.

It will be a particularly important AGM due to the Review reported earlier
in this Newsletter and also being the last one before the General Election