DFNHS

EDITORIAL June 2015

Hearts, Minds and Votes

As the analysis of the election continues there is general agreement that the NHS featured prominently. But the end result is we have a government set to continue with fragmentation and privatisation. The BMA and King's Fund have been quick to point out there is much to be done to protect the quality of the service under severe financial constraints.

Amongst the ironies of the results are polls that show the English public wants the NHS, has little appetite for privatisation and yet voted in a government that prioritises tax cuts over spending on welfare, with inevitable consequences for public health.

Prior to the election there was much talk of 'multi-party politics'. That has happened although not exactly as expected. We now have a different party dominating each of the four countries that make up the UK. How the pro-NHS parties influence UK policy will be politically important and a source of hope for us

As to ourselves, this is our second issue since opening our membership to all doctors. We are beginning to recruit GPs and we shall be aiming to become better known through articles in the general press and GP-specific publications.

The reorganisation at Manchester, now known as Devo-Manc will be a hot topic – there will be a bill before parliament to present the details and I have included two initial responses to the proposal (one a nightmare vision). We are at a very early stage and concerted effort could both preserve the principles of the NHS and develop improved care through integration with social services. There will be much work ahead.

The agenda for the next few years is likely to mean hospital closures or downgrading vital departments such as A&E so that DGHs cannot provide a full range of services. Reviews of the acute services are being carried out across the country. Some rationalisation may be reasonable to bring economies but they must always be based on clinical benefit.

We must learn from past mistakes. When Keogh reviewed the trusts with the highest mortality rates he found that in general they had given finance a higher priority than clinical matters and, following the necessary improvements in staffing levels required by his and Francis's report, most trusts are in deficit.

The simple truths are that the NHS is highly efficient but is underfunded and there is a real danger that the government will use the current problems as an excuse to continue their privatisation agenda.

To take our message to the public and to doctors wishing to preserve the NHS we must continue to assert that the remedy for underfunding is investment and use opportunities such as high profile closures and reconfigurations to make our points. The exposure that attempts to close Lewisham achieved shows how government policy affects people directly. I expect more such opportunities in the near future – DFNHS will be there, with our new banner to add our voice. We have already started to develop resources to draw attention to our aims, and recently appointed a professional campaign and public-relations manager (Mr Alan Taman – details on the website) to further them and give the organisation's communications a professional focus.

I am grateful to David Levy for picking up many issues in the wake of the Whips Cross debacle and to all contributors to this issue.

We welcome comments. We shall have a letters section in the next edition, which will be undergoing layout and content changes to more closely reflect our new aims and wider membership, and comments can be posted on the website.

Eric Watts
Co Chair

News and Comments

During the election campaign I met with people from many other bodies who share our aims to protect and rebuild the NHS.

One of the events recorded on Facebook was the 'Bring back the NHS' event described in 'What the NHS means to the British Public' and it was stimulating to meet so many young people being passionate about the future of the service. Politics is in a state of change, fewer people are joining the old political parties but more are aligning themselves with socially important issues. Speaking with them they valued the knowledge and experience DFNHS can bring to help add gravitas to their activities and I look forward to meeting them again as new issues arise.

For those who do not use social media – I recommend you give it a try. They may currently lack the considered depth and context of older forms of media, but if you can see beyond the initial 'noise' their power to connect and influence is impressive and will surely increase. You tube is easy – you just type HYPERLINK "http://www.youtube.com"www.youtube.com and a huge amount of videos are available including the 'Bring back the NHS' event, for example. Facebook has many people who are working to protect and improve the NHS. You can join in without giving away any of your privacy, remain anonymous and look at whatever contributors put on their sites for public view.

Twitter has the advantage of speed – almost instant, again you can choose to be anonymous or use a nom de plume. Although not perhaps as intuitive to use as e-mail or Facebook, the good news is you can find many people serious about supporting the NHS as well as some very entertaining material, and of course our very own Twitter feed, @Doctors4NHS.

Most hospitals are overspent, usually because they are underfunded, and currently Monitor are looking in to this – at a recent conference of NHS Providers (i.e. mostly hospitals) we were told they have assessed 30% of acute trusts to be sustainable, 40% to be marginal and 30% to be unsustainable; we were not told which these were nor what plans Monitor had for those considered unsustainable.

I later learned that Monitor have published 'Facing the future: smaller acute providers' questioning the 'sustainability' of hospitals with an income of less that £200M and regarding £300M as a healthy size – they did include a qualification – 'We did not find a consistent relationship between size and indicators of quality' and they went on to say:

'It is beyond the scope of this study to do a full statistical assessment of the relationship between clinical outcomes at hospitals and size, so we cannot conclude with certainty on the relationship between size and clinical outcomes. For example, these indicators do not enable conclusions to be drawn about differences in quality in individual service lines. There are also noted limitations to using such indicators as measures of quality.'

Oh dear? Did we forget the principle of validity? It is a real concern that they put out the report without establishing a sound relationship between size and quality which makes me wonder if this is part of a softening up process to bring in reconfigurations which will reduce bed numbers further (already reduced by 50% in 30 years).

The arguments against were given in last June's Newsletter and since then I found this paper - Emerg Med J 2007;24:665–668. doi: 10.1136/emj.2007.047654, stating:

'Our data suggest that a 10-km increase in straight-line distance is associated with around a 1% absolute increase in mortality.'

There is more on this on our extended new website – in the section on our Launch in Portcullis House in February – with pictures of the team and a transcript of our talks. Peter Trewby gave a graphic account of how reconfigurations affect the everyday experiences of patients – not always for the better.

There is a brief section on the work of the Centre for Health and the Public Interest and a list of their reports – one of which is quoted in the item on the conference on manslaughter and preventable harm. The conference came about because of a surgeon being held entirely responsible for the death of a patient, although the reality is that there were many failings in the care provided by the private hospital where the operation took place. As private hospitals are now receiving 25% of their funds from the NHS this is a matter for NHS commissioners and the public interest.

And finally if you're watching the Labour leadership contest you may be interested in the report of our meeting with Andy Burnham, which was in the September issue – we found it very useful and we could work with him in the future. All past issues of the Newsletter can be found on the website (www.doctorsforthenhs.org.uk).

Eric Watts
Co Chair

The Devil in Devo

'The Devo Manc plan is a blitzkrieg attack to fast-track the reconfiguration of the NHS into new business models ready for private company take over.' Keep Our NHS Public Greater Manchester / April 15, 2015

Greater Manchester Association of Trades Union Councils (GMATUC) called a mass NHS emergency protest rally to protest against the devolution of the Greater Manchester NHS Budget, called 'Devo Manc', without public scrutiny.

An emergency resolution passed by GMATUC stated in part:

'As trade unionists we can only suspect that the break-up, dismemberment, rationalisation and further privatisation of the NHS in England (under the banner of public service reform) is precisely what it's all about, and being hurriedly imposed to avoid any such thorough examination, scrutiny and proper public debate of the issue.'

The motion ends by calling for a referendum on ALL the Greater Manchester devolution issues.

On 27 February 2015 Chancellor George Osborne and the chief executive of NHS England Simon Stevens held a press conference to announce a 'Memorandum of Understanding' for 'Devolution of health and social care in Greater Manchester' (GM).

This marked a deal to parachute in a £6bn pooled health and social care budget, direct from the Treasury to a new GM Strategic Health and Social Care Partnership Board – in shadow form from April 2015, and statutory by April 2016.

This board contains leaders of 10 Local Authorities (LAs), 12 Clinical Commissioning Groups (CCGs) and representatives of NHS England (NHSE), as well as providers and voluntary organisations.

The Combined authority of GM consists of LAs Bolton, Bury, Manchester, Oldham, Rochdale, Tameside, Salford, Stockport, Trafford, Wigan – an area of 5000 sq miles, and 2.7m population.

This deal came as a complete surprise to everyone but a few top council leaders, such as Sir Howard Bernstein and Sir Richard Leese, who had secret negotiations with Osborne for 6 months and then persuaded the 10 LA leaders (eight Labour) to agree. Members of the public, NHS staff, trade unions, and Members of Parliament had no idea.

The deal dictates a massive change in the way that commissioning and funding of healthcare is organised in GM, changing the deckchairs again, beyond the Health and Social Care Act 2012.

The purpose of it, is to drive through the Healthier Together programme to close 4-5 acute District General hospitals (DGHs) in GM , and divert the funding into the new business 'models of care' outlined in Simon Stevens' Five Year Forward View (FYFV).

The budget for health and social care is to be pooled. The commissioning for health and social care is to merged together into Joint Commissioning Boards (JCBs) of local councils and CCGs.

There will be four tiers of new management. The Strategic Partnership board will be supervising a JCB for GM, standing over localised JCBs.

At the very top will be a Programme Board including Simon Stevens, John Rouse from the Department of health, leading local figures in the Healthier Together programme, and Graham Urwin from Staffordshire and Shropshire.

(Staffordshire is the area where contentious reconfigurations have just taken place with the removal of A&E, paediatrics and maternity from Mid Staffs hospital and a £700m, 10 year, privatisation deal for Staffordshire's Cancer services.)

NHS England has representatives on every one of these boards. So despite the appearance of 'local decision making', NHSE will enforce its own policies.

These huge administrative changes will allow the combining of funding streams from NHSE, the CCGs, the LAs, Public Health England, mental health and social care all into one pot.

The Joint commissioning boards will then be able to re- direct this funding, away from our District General Hospitals and GP surgeries and tertiary care, into the 'new models of care' outlined in the FYFV.

The Memorandum states 'GM is to be a trailblazer for the objectives set out in the NHS Five Year Forward View'.

The main objectives of the FYFV presented by Stevens in October 2014 are to impose:

- 'New models of care' modelled on the US healthcare system.

- A new 'modern workforce' fit for these new care models: a workforce with local pay, 24/7 working, flexible and able to 'cross boundaries', highly efficient with increased productivity and reduced skill mix, with changed terms and conditions, altered training, and with a huge new role for volunteers.

The ' new models of care' include:

- Large out-of-hospital providers; 'Multispecialty community providers (MCPs)' and 'Primary and Acute Care systems (PACs)'.

- 'Small viable hospitals' (which would be dumbed-down DGHs without proper A&Es).

- 'Specialised care' such as cancer and elective orthopaedics on networks with prime contractors.

- 'Networks of emergency and acute care', with a halving of the number of Type 1 A&Es.

Steven's key drive is to get the MCPs and the PACs off the ground in his so-called 'Vanguards' of 'integrated health and social care'. GPs' surgeries are being coerced through underfunding to federate up into these MCPs, which are designed for populations of 50,000 to 300,000 and could even take over a downgraded local hospital.

These would contain medical and nursing staff, social workers, care assistants 'new roles' and lots of management. The idea is that these would provide primary care, and elements of elective hospital work, mental health, public health, and out-of-hours emergency calls.

They would tender for a new contract and could be prime contractors doing commissioning and providing, and could sub-contract out pathways of care. Patients would be registered with a GP and the work would be done on a capitated budget, which could not be overspent.

MCPs and PACs are modelled on American health maintenance organisations such as Kaiser Permanente. They make a profit by incentivising staff to limit hospital referrals and care.

It is for these that the health budget has been merged with the social care budget, as they will be providing both health and social care.

And of course, putting the provision of health and social care in the same contract, makes it easier to start charging for healthcare in the same way as for social care. Patient charges are clearly on the agenda of an incoming Tory government.

The propaganda slogans of ' joined up care' and 'integrated care' of the Vanguards, are a clever disguise for prime contracting and subcontracting, i.e. disintegration and outsourcing.

These objectives have nothing to do with improving patient care, but of opening the way for takeover of NHS clinical services by multinationals, to make a handsome profits.

Already, we see our NHS in crisis with a severe lack of beds and staff.

Unions and campaigners and the public must oppose this plan from the start. Devo Manc is part of much bigger devolution plan with pretensions to devolve £22bn of public funding to the GM Combined Authority – to commission policing, planning, housing, transport, training, etc.

It is a poisoned chalice. The responsibility for making the billions more of public spending cuts will then rest with the devolved authority, and a mayor, whichever government gets in at the election.

The Devo Manc plan is a blitzkrieg attack to fast-track the reconfiguration of the NHS into new business models ready for private company take-over.

It is a declaration of war on the health unions and the workforce, as it depends on ending Agenda for

Change and doctors' current contracts, and pushing through local pay and 24/7 working. They want a drastic reduction in jobs and more unskilled workers and volunteers, to hike up 'efficiency' and cost cutting, so that the circling private companies can make massive profits out of public sector contracts.

They want the end of a national public sector workforce with high levels of training.

The devolution deal is designed to use local councils and NHS leaders to break up the NHS area by area, using new commissioning structures and methods of funding, all dictated from the top. The aim is to end the NHS as a national publicly provided service. Then use it as a 'test bed' and 'trailblaze' similar deals all over the country.

Above all there must be a huge struggle to defend what we have: all our DGHs, our GP surgeries, our ambulance services, our community services, public health, and what's left of mental healthcare. And our public sector workforce.

The same devastation is being wreaked on all the public services. United action by the unions is needed to bring back these services into public ownership. To defend our District General Hospitals and GP surgeries, and the NHS as a nationally publicly funded and provided service, Devo/Manc must be stopped.

Anna Athow
Retired surgeon

Manchester - The Birth & Death of the NHS

On 5 July 1948 in Manchester Labour Secretary of State for Health Aneurin Bevan announced the birth of the NHS.

On 27 March 2015 in Manchester Conservative Chancellor of the Exchequer George Osborne signed a piece of paper that would bring about the end of a *National* Health Service.

These two events are 67 years apart but signal huge differences in how health care would be provided to the population.

In a surprise announcement just weeks before a General Election the Tories signed a deal with the Greater Manchester Authorities – which includes Manchester, Bolton, Salford, Oldham, Stockport, Wigan, Tameside, Trafford, Rochdale and Bury Council. A huge area. (The actual deal can be read here:http://www.agma.gov.uk/cms_media/files/mou.pdf). It hands over £6bn from central government to a new organisation to run health and social care services for 2.7 million residents in the Greater Manchester area. On the face of it this may sound attractive: no longer having Whitehall poking its nose into local health issues/ But there is much to be concerned about.

The very fact this deal was hurriedly signed off just before a General Election should ring alarm bells. Many local MPs had not been aware of how advanced the negotiations were and more shockingly the public had not been consulted or asked to make a decision on this huge change to their local NHS. To the horror of many, Councillor Jim McMahon, Labour leader of Oldham Council, told the BBC Sunday Politics programme on 1 March 2015 that 'the changes happened too quickly to ask the public what they thought'.

Local GPs, who were promised by the Tories to be more involved in local healthcare with the Health and Social Care Act, were kept in the dark and not given any say in the matter.

This all leads to the conclusion that it has been a done deal behind closed doors and rushed through prior to an election.

Local Authorities often outsource services as they cannot provide them from their own resources. This was one reason why Aneurin Bevan didn't offer healthcare provision to Local Authorities in 1948. Bevan ensured a national service was offered to all across the UK with no regional discrepancies and not at the whim of councillors. This deal also significantly advances the risk of charging for services when social care is added into the mix of health care provision. Already in parts of Manchester cuts to services are occurring – as we have seen in Salford already (http://www.manchestereveningnews.co.uk/news/greater-manchester-news/salford-cuts-council-approves-spending-8721581). With further severe cuts to

Local Authorities in the coming years (promised by Tories and Labour) where does this leave health services under this devolved deal?

There are a number of reasons this deal has been done, and many of them help the Tories:

- Andy Burnham is put on the spot by Osborne, trying to wrong foot him in the election period. The local Labour leadership have not done Andy Burnham any favours!

- Osborne is seen as the hero of the day – riding to the rescue of Manchester.

- The push for devolution in Manchester helps the 'English votes for English MPs' cause that the Tories are desperate to see come about. Why do they want this? Because it will lead to a Tory Government in England indefinitely. Labour relies on MPs from Scotland and Wales to win majorities in Westminster. The Tories want to stop this.

- Osborne puts his mark on health policy to try and eradicate the disastrous health policies of Andrew Lansley. With one flick of the wrist by signing this deal he has swept away many of Lansley's 'reforms'. Lansley's Health Act didn't last a Parliament!

Local patient groups, local GPs, local NHS staff, local MPs, national medical organisations and patient groups need to be all over this deal like a rash. They need to ask where the consultation was and why democracy has been sidelined. They need to ask what the implications are for their care and what happens when Local Authority budgets are cut further in coming years.

The Manchester Devolution deal is hugely worrying and has many risks attached to it. There is likely to be much debate on the deal in the coming months but one thing is for sure. The deal was signed, sealed and delivered without a single debate or consultation with those it will most likely affect: patients and local NHS staff.

David Wrigley

First published on David's blog, http://drdavidwrigley.blogspot.co.uk/2015/03/manchester-birth-and-death-of-nhs.html)

PUBLICITY AND RECRUITMENT

As noted elsewhere in this Newsletter, these are topics of renewed importance following our expansion and change of title, not to mention the clouds gathering over the NHS which are in no way diminished by the recent General Election.

As always, we welcome suggestions from other members regarding colleagues who express views in line with ours and might therefore consider joining us.

Their names and specialty are sufficient for consultants and for general practitioners their geographical area. Hospital trainees and those in permanent sub consultant posts are harder to locate so their place of work is needed.

We are also developing various types of publicity material and enclose a copy of one of them, a full colour leaflet explaining DFNHS and its purpose.

Please give to any doctor who you think might be interested. If you can use more of these leaflets just let us know and they will be sent to you

Peter Fisher

Manslaughter and Preventable Harm

No doctor goes into work intending to harm patients. However, in this world of increasingly complex and interdependent medicine, mistakes can, do and will always happen[1,2]. The criminal prosecution and subsequent imprisonment of surgeon David Sellu for manslaughter following the death of a patient under his care has sent shock waves through the medical profession[3]. It has also provided the impetus for a meeting on 'Manslaughter and Preventable Harm' which took place in London in April. Ian Franklin, vascular surgeon, opened the meeting. Ian, together with Dr Jenny Vaughan, consultant neurologist, jointly organised an excellent event.

Mr Franklin described how David Sellu, a general surgeon with a previously blameless clinical record, had been referred a patient who had developed abdominal pain a few days after a total knee replacement in the Clementine Churchill, private hospital in Harrow, North London. The patient was seen that evening and a CT scan arranged for the following morning. This revealed free gas in the abdomen; a diagnosis of a perforated viscous and peritonitis was established. There was an unfortunate delay in getting to the operating theatre, mainly because of the difficulty in finding an anaesthetist, since there was no on-call anaesthetic rota for that hospital. Sadly, the patient subsequently died and this fatal outcome set in train the eventual criminal prosecution and imprisonment of Mr Sellu for gross negligence and manslaughter.

Michael Powers QC, a qualified doctor and a barrister, then provided a historical review of medical crime pointing out that to obtain a successful prosecution the jury had to be convinced that the medical practitioner was not merely negligent, but criminally negligent, in his or her 'disregard of life'. He exemplified this with the cases of Richie Williams and Wayne Jowett, two teenagers with leukaemia, who both died as a direct result of vincristine being administered intrathecally as opposed to intravenously, in Great Ormond Street and in Nottingham Hospital respectively. In both cases the doctors were prosecuted, but only in the latter was the prosecution upheld, despite the clear similarities between the two scenarios. Neil Dalton from the Criminal Prosecution Service (CPS) then described the process by which the decision to prosecute is made. He stated that the opinion of independent medical experts almost always heavily influenced this decision.

Professor Colin Leys then highlighted the patient safety deficiencies of some private hospitals, especially the smaller ones outside central London. He pointed out that although they now received 25% of their revenue from the NHS, there was little or no requirement for them to report patient safety data such as near misses'. He highlighted the issue of poor record-keeping, and particularly criticised the lack of on-call anaesthetic cover in many private hospitals.

Lawyer Oliver Quick then described his empiric research findings that highlighted the vagueness of the definition of 'gross negligence' and concluded that it could result in unfairness. He also suggested that there seemed to be a disproportionate percentage (almost 50%) of prosecutions brought against non-white doctors. This raised the worrying possibility that there is racial discrimination against non-Caucasian medical practitioners when serious medical accidents occur.

Ian Barker, senior solicitor for the Medical Defence Union (MDU) then agreed that there has been a very noticeable upwards trend towards doctors being investigated by the police, and subsequently prosecuted. The coroner, relatives and the hospital where the mishap occurred can all inform the police. Once an investigation is commenced, the process often focuses exclusively on the role of the individual clinician, rather than the team or the institution. He emphasised that no NHS Trust or private hospital board wants to be prosecuted for 'corporate manslaughter', so they were not always supportive of clinicians who make errors. He also mentioned that it is usually easier to achieve the conviction of an

individual doctor, as opposed to a particular private or NHS institution.

Mr Ken Woodburn FRCS then touchingly described his own personal agony following a police prosecution for manslaughter after a teenager with leukaemia tragically died following a mishap during insertion of a subclavian line in 2001. Mr Woodburn described the isolation he and his family felt, as well as the bitterness about the process, which still lingers. Eventually he was cleared of the charge of manslaughter by the jury, which deliberated only for an hour. ' I was working with a team that I'd never worked with before. It was an extra list on a Saturday morning to achieve waiting-list targets forced on me by managers, and it was an extra case added to that list', he stated. He also complained about the lack of support from the Trust during the investigation and trial, and emphasised that as a doctor these days you are ' only one error away from a manslaughter trial'.

Peter MacDonald, surgeon, emphasised the variation in skill and expertise of so-called 'expert witnesses', whom he felt were sometimes less than impartial and too often simply followed the line of the prosecution, whose objective is to obtain a guilty verdict. In the discussion there was concern that the CPS could change or 'flip' their selection of expert witness if they felt that their original choice was insufficiently robust.

One of the authors of this report (RSK) then stressed the point that most medical accidents are the result of an 'error chain' which leads inexorably to one individual committing the eventual 'fatal mistake'[4]. A 'systems' as opposed to a 'person' approach to medical accident investigation allows the team and the institution to learn from the mistake, instead of focusing the blame exclusively on one individual doctor and making him or her the 'second victim' [5]. In the aviation industry and other high-risk industries this lesson has already been learnt, and applied for more than two decades.

Jenny Vaughan then summarized the meeting as follows: the David Sellu case illustrates some of the problems associated with the criminal prosecution of a clinician after a mishap that results in a patient's death. The police and the CPS tend too often to focus purely on the clinician who makes in their eyes the 'fatal error'. In fact, as a result of the complexity and interdependency of modern medicine, there is almost always an error chain involving multiple other individuals (in David Sellu's case, a resident medical officer, with a poor grasp of English, and the lack of an on-call anaesthetist). In other words, in modern healthcare, it is now usually the team as a whole that is at fault, as opposed to a single member of the team. This fact seems to have escaped the police, the CPS and the criminal justice system.

Bernard Jenkins, Chairman of the Public Administration Select Committee, has recently commented that the handling of clinical failures 'fails to foster positive outcomes or leaning from mistakes. Instead there seems to be a culture of blame and of responding only to mistakes'. We most certainly agree; there really has to be a better way forward than imprisoning a doctor for two and half years in the twilight of his career. If you, the reader, have any observations or comments of your own on this or related issues, please do add them to the blog entitled 'Should doctors go to prison for clinical negligence?' on the Trends www.trendsinmenshealth.com website.

Roger Kirby, Ian Franklin
and **Jenny Vaughan**

References

1. Stelfox HT, Palmisani S, Scerlock T et al. The 'To err is Human' report and patient safety literature. Qual Saf Health Care 2006, 15:174-178.

2. Leape L, Berwick DL 5 years after 'To Err is Human', what have we learned? J Am Med Assoc 2005, 293: 2384-2390.

3. Kirby RS, The consequences of medical mistakes, the stakes are getting higher. Trends in Urology and Men's Health. May/June 2014.

4. Kirby RS. Learning the lessons from medical errors. BJU Int 2003 Jul 92:4-5.

5. Kirby RS, Supporting 'the second victim' after a medical error. Trends in Urology and Men's Health, May/June 2014.

Brace Yourselves for the Tsunami

The first Conservative government in nearly two decades must be seeking to discharge a whole pile of pent-up anger against the public sector, and although we may giggle at David Cameron telling us he felt all 'pumped up' by the prospect of 5 years in the driving seat, we have to assume they mean serious action – and soon. It's difficult to know where to begin, because so many trails have been carefully laid since 2010 that a majority could go cold without impeding the grand flow (and even if they do, the converse principle – never let a serious crisis go to waste – will always reap benefits in the neoliberal imagination). We were unaware of many of the initiatives quietly bubbling away while we were all fulminating about the Health and Social Care Act. For example, I've uncovered the 70-page Statutory Guidance for Trust Special Administrators Appointed to NHS Trusts, for use during the Regime for Unsustainable NHS Providers, published by DH in February just before election purdah. I expect lots of copies will need to be printed off.

Funding

Everyone, including the government, is wholly confused by the prospects for NHS funding. My understanding is that £30 bn of savings are required by 2020; £22 bn is supposedly going to come from the 2-3% annual efficiency savings, which of course have never been achieved in the past, with the remaining £8 bn made up by the Conservatives' promised extra funding. Jeremy Hunt has promised 5000 new GPs over this parliament; another fantasy notion as huge numbers of existing posts can't be filled, and we are not far off 36 000 new doctors to bring us up to the EU average (Figure 1). When Hunt was asked about funding for the 5000 on Today (18 May) he claimed it would all come from the £8 bn (I reckon about £400 m in salaries alone). Stevens will have to be as inventive in his accountancy as the government, but their EEGs are synchronised so they won't find that a problem.

Public-friendly fantasies

Sir Bruce Keogh has demanded 7-day working in hospital – it seems to be blurring into general practice as well – by 2017. The requirement was stimulated by evidence for excess mortality at weekends, though nobody can exclude the possibility that sicker people come into hospital at weekends, and it probably doesn't apply to all conditions. The BMA, newly vertebrate, has refused to contemplate 7-day working – which will mean shifts for all – into the new consultant contract, but that was under the coalition. Keogh will certainly get his way.

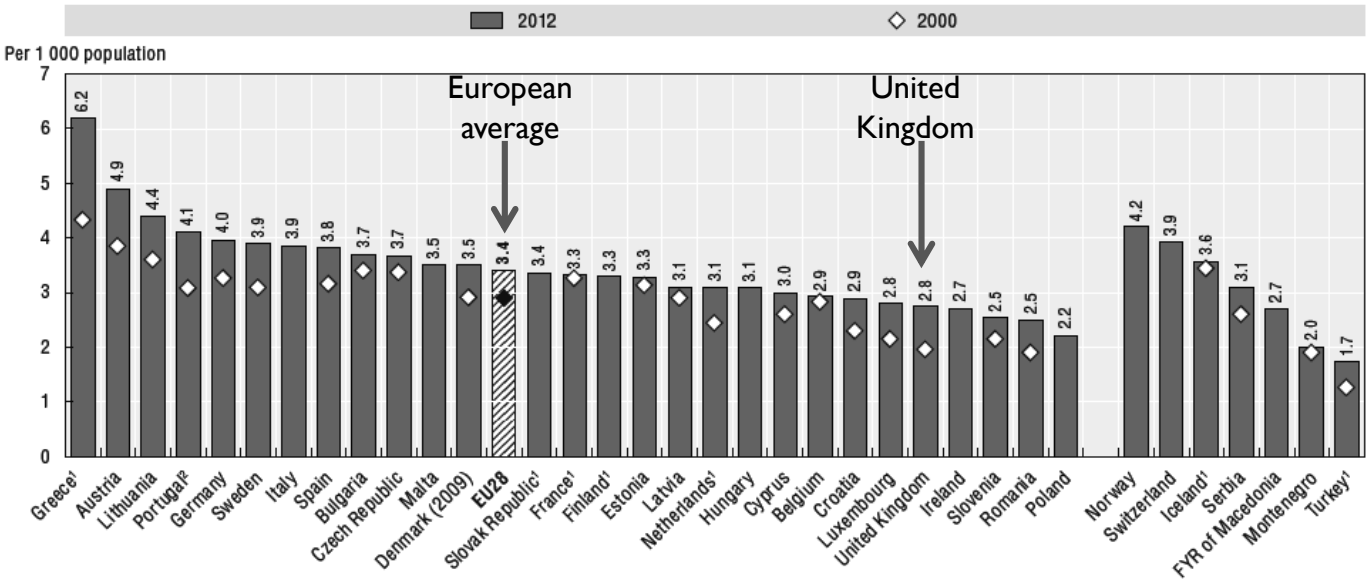

Figure 1. *Doctors in the EU (OECD). 5000 would be a good start, but in order to bring us up to the EU average we'd need ~36 000*

The result may well be a downward wobble in weekend mortality, but shifts will reduce the number of consultants available during the week. DH may have to work very hard on the statistics. Among the advanced European countries we have the lowest ratio of doctors (Figure 1) and nurses, and there are no countries I know of that run 7 day services, even with more doctors and funding.

Foundation Trusts and the Trust Development Agency (TDA)

We are habituated to terminology frameshifts of the knight's move kind: recall, for example, the 4 hour A&E wait 'target' that morphed into a 'standard', partly so that the government could claim a reduction in the number of targets they were demanding. More serious redefinitions are underway, and as always we should look to education for models. Ministers and officials are pressurising local authority-run schools deemed to be 'coasting' (i.e. doing perfectly well, thank you) to convert to Free or Academy schools. In the same way, impatience with Trusts that are still not ready for Foundation status means they don't have much time left. One of the current government darlings, the CEO of Salford Royal Foundation Trust, Sir David Dalton, was quoted in the Health Service Journal:

'It's now over 10 years since FTs first appeared. [Their] standards are reasonable … so … organisations that haven't been able to provide a convincing case after 10 years … the NHS and the public [will] ask whether they'll ever be able to reach the standards that are necessary. … we don't seek to preserve the organisations in their current form if [they] aren't able to deliver high standards of care reliably and economically.'

He was commissioned by the last government to report on Examining new Options and Opportunities for Providers of NHS care (December 2014). Shots across the bows abound – I'd never heard of batched procurements before:

'The TDA should consider accelerating the solutions for patients and communities currently served by organisations in persistent difficulty, by running batched procurements for category B1 and B2 NHS Trusts.' [see below]

The largely invisible but extremely impatient and authoritarian Trust Development Authority (TDA) uses an identical hymn sheet:

'A minority of local health economies have for some years been in significant difficulty, and have struggled to develop and implement credible plans to recover their position. For these systems NHS England, Monitor and the NHS Trust Development Authority (TDA) will in 2015/16 become more jointly engaged, acting in concert. We will design and apply a new "success regime" intended to help create the conditions for success in the most challenged health economies.' Forward View (December 2014)

The TDA classification system

In a strange outburst of transparency in November the TDA issued a preliminary viability classification of the 93 trusts it manages. Anna Athow drew my attention to it, first made public in the HSJ in April 2014. The TDA now plans to publish it in the summer; the delay was not of course caused by the political difficulties it may have uncovered in what were thought to be marginal Conservative seats, but because of some problems with a row over tariffs. Most organisations were told their TDA class in during October (Table 1), but the terminology will naturally move from 'closure' to 'unustainability'. I presume this will mean a very tight time-scale for reducing DGH numbers (Monitor appears to be paving the way – see news items). The Conservatives will want this nasty business over with in the early part of the parliament.

TDA Class	Significance
A1	Clear and credible plan for becoming FT in <2 years
A2	Predicted to become FT within 4 years
A3	Potential Foundations but with no 'clear and credible plan and time line'
B1	Unsustainable – acquisition by another organisation is likely to be best route to sustainability
B2	Recommended options: franchise, management contract or other innovative [sic] organisational form
C	Further work required to determine the organisation's future [presume irretrievable basket cases]

Table 1. *Detailed classification for the likely fate of the remaining 93 English Trusts*

Special measures

'Special measures' has recently acquired a particularly unpleasant populist twang, which will certainly encourage a more liberal application. Keogh used data from Dr Foster to heavily suggest to the media that mortality rates in hospitals placed in special measures improved. The graph below from the Dr Foster report (Figure 2) shows however that the difference in SHMI rates was already narrowing before special measures, on a background of continual improvement over many years: regardless, when was 'special measures' intended to improve hospital mortality (which purportedly remains high in the UK compared with other countries, though I haven't been able to get hold of the data widely headlined back in 2013)? This is retrospective data-dredging (or at best hypothesis-generating) which would be rejected by peer-review if ordinary clinicians submitted it to a journal. It's difficult to understand how Keogh, a responsible and highly-regarded clinician, could promote such dismal science.

Destructive reorganisation without the need for further top-down restructuring

Simon Stevens' 5 year plan, together with the DH and the big quangos (CQC and NHS England) will add another degree of incomprehensibility (or according to your viewpoint 'variety' or 'plurality') to the organisations involved in the NHS. Chaos is already ubiquitous. The only left of centre health think tank, the Centre for Health and the Public Interest, published a very clear document in April (The Contracting NHS) on the disastrous landscape of commission. Key points:

- There are about 53 000 contracts between the English NHS and private sector providers, of which CCGs issued about 15 000, worth £9.3 bn (this excludes dental, ophthalmic and pharmacy services).

- There has been a linear growth in expenditure from 2002/3 to 2013/14, with, interestingly, only the merest hint of a slow-down around 2010-11 (it's good to see that some businesses are recession- and austerity-proof).

- CCGs employ about 12 500 people to commission contracts and 'manage' them (though the majority are barely supervised). Contracts are confidential and details not accessible through FOI.

- Most disturbing of all: the rotweiler operating arms of CCG commissioning – the so-called Commissioning Support Units (CSUs) – already with a poorly defined legal status, and a legendary record of saying 'no' to treatments in multiple ways – are due to be hived off as private companies by April 2016. CSUs are overt cost-cutting organisations that allows CCGs to wash their hands of distasteful decisions, nearly always to withhold treatment, and often to the demonstrably disadvantaged, using nasty pseudo-egalitarian rhetoric (your patient can't have their recommended treatment because it would disadvantage others with the same condition). Their decisions are nearly impervious to legal challenges, and once they are further galvanised by cost-cutting incentives, they will be only too happy to rigorously enforce the ever-growing list of 'procedures of limited clinical value'.

The new care models of Stevens' 5 year plan

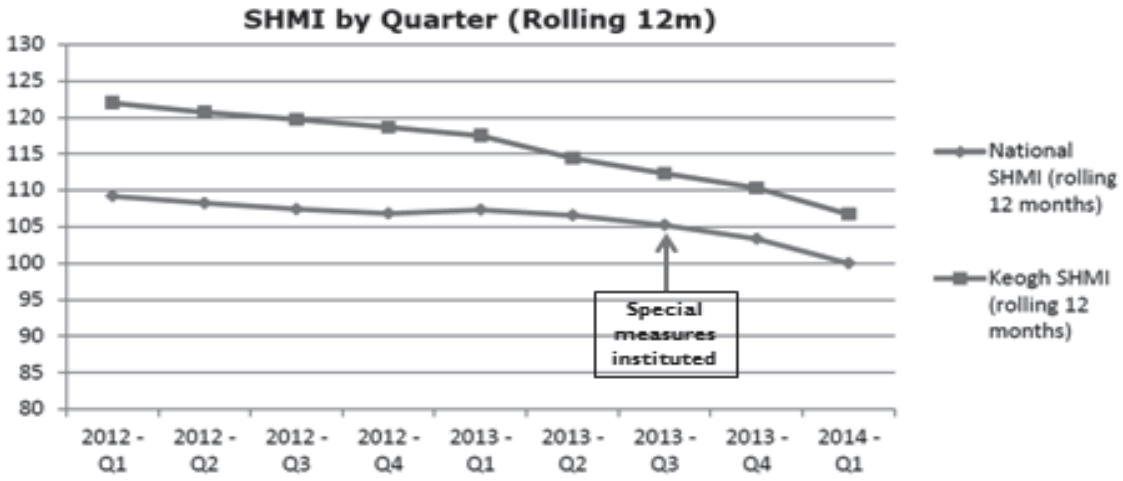

Figure 2. *Special measures probably don't cause hospital mortality (SHMI) rates to fall (data from Dr Foster).*

The first 29 (Vanguard) schemes were announced on 10 March. They fall into three groups, discussed in Anna Athow's review of Simon Stevens' wildly acclaimed plan revealed in October 2014:

- 9 Integrated Primary and Acute Care Services (integrating general practice, hospital, community and mental health services).

- 14 Multispecialty Community Providers – moving specialist care out of hospitals into the community.

- 6 Enhanced Health in Care Homes – offering older people better, joined up health, care and rehabilitation services.

Underneath is a seething substructure of impenetrable contractual arrangements. Just look at what one of the MCP Vanguards (Calderdale Health and Social Care Economy) comprises:

- Pennine GP Alliance (23 out of 26 Calderdale practices – what happens to the remaining 3?).

- Calderdale and Huddersfield Foundation Trust.

- Calderdale Clinical Commissioning Group.

- Calderdale Metropolitan Borough Council.

- South West Yorkshire Partnership Foundation Trust.

- Locala Community Partnerships (NHS) We are a Community Interest Company (CIC), an independent, not for profit social enterprise (employing 1200 people).

- Voluntary Action Calderdale (representing 128 health-related 3rd sector organisations).

There is a contract going out at present for a Care Closer to Home idea (Locala has submitted one of the two tenders), but I can't make out where this will sit with the Vanguard site.

We are heading towards an ever-more centralised system of axe-wielding heavy- handed organisations, all with a strong neoliberal flavour (TDA, NHS England, CQC and Monitor). These will be complemented by their mates in the spineless quangos, such as the Co-operation and Competition Executive within Monitor (even its predecessor, the Co-operation and Competition Panel, maintained some kind of independent fig-leaf), and the hugely influential King's Fund, beautifully described by John Lister as 'servile'.

Bureaucracy reduction v.23.1

Finally, a follow-up of an article I wrote for the Newsletter back in May 2013. The government response to the Francis Report included an undertaking to reduce bureaucracy by at least one-third (though I wasn't sure at the time how you measure bureaucracy, especially when the playing field seemed to be upward sloping). The NHS Confederation was tasked with drawing up the paper-chase reduction plan. Beyond the start of 2014 I can't find any trace of their no doubt heroic endeavours, so I think we can be confident that the government's promise hasn't been met. The massive funding of NHS bureaucracy is one of the reasons why our health care outcomes are so universally grim in European comparisons. The new government, committed more than ever to reducing the paper chase, should be reminded of its unfulfilled promise. It's started brilliantly with yet another quango that slithered under the door: a national New Models of Care Board to support the different care models in the 5 year plan. More are probably being devised as you read this.

David Levy

The Growth of Managerialism

In James Burnham's *The Managerial Revolution* (1941), Burnham saw the impending end of capitalism and its replacement by 'managerialism', in which a social group or class which Burnham called managers, would seize dominance, for power and privilege, and become the ruling class. George Orwell was probably influenced by it in writing *1984* and it was a theme in 1950's US science fiction as in *'The Year of the Comet'*, *'Player Piano'* and *'The Space Merchants'*. Burnham's view was that ownership of the state, the operation of state power and the subjects, were each occupied by a different group, with power and direction provided by the managerial class.

Perhaps we are seeing Burnham's ideas now coming to fruition, although Burnham did not foresee the neo-liberal revolution which has provided the replacement to his 1940's statism of the 'New Deal'. Managerialism is by no means restricted to state organisations. Most transnational corporations have more wealth and power than most of the world's states, and increasingly politicians' power is curtailed by the global decisions of private finance. TTIP represents the opening of the final battle for supremacy between the transnational corporations and the nation states.

In 2013, the anarchist David Graeber wrote a provocative article, [2] in which he described how pointless work has increased: 'Corporations ruthlessly sacked the skilled workers, but, through some strange alchemy no one can quite explain, the number of salaried paper-pushers ultimately seems to expand, [and] much of their time is spent organizing or attending motivational seminars…'

On a smaller scale, a theme runs through several accounts of large state bodies and here are three examples. Local authority councillors tell me how councillors live under the illusion that they had power, whereas in reality very little can be done against the wishes of the Officers of the Council. The same old games are played out as they were in *'Yes Minister'*. Secondly the excellent film *'Spirit of '45'*, shows us that the transformation of the private enterprise coal industry into the National Coal Board, had limited advantages for the miners. The same bureaucratic management ran the Coal Board as used to run the large private coal companies.

Of course our own beloved NHS, a state in microcosm, is my best example. Before Margaret Thatcher's malign interference in the NHS, skilled administrators were quietly and efficiently running the housekeeping of the NHS, and did not involve themselves in clinical affairs. Decisions about the development of the local clinical service were taken in consultants' meetings, at which the 'Administrator' attended. The fact that these decisions could rarely be put into practice, was down to a growing layer of management at 'Region' and in the Department of Health. After Thatcher, general management was firmly ensconced in NHS Trusts, many managers sourced from Senior Nursing Officers.

I suspect most clinicians have realised that, however expert they may be, they have little influence on developments in local services provided by their NHS Trust, no matter what clinical need is being addressed. Planning and development is mainly absent from the concerns of Trusts. Decisions are primarily driven by finance, because it is saving money that most reliably produces rewards for managers from Performance Related Pay. Note the similarity with the banking industry: investigating businesses seeking investment is time consuming and requires expertise – better sell mortgages.

I believe the managerial influence is greatest in mental health services, because of psychiatry's enforced isolation from general medical services and managers' attitude that 'mental health issues' (not, you note psychiatric disorders) can be solved by anyone. Managers are appallingly ignorant about, for example, the number of psychiatric beds needed for a given area, dependent on its socio-economic index.

Wide-reaching actions are taken without any evidence or piloting at all, for example, the splitting of consultant psychiatrists into those for the community and those for in-patients, a retrograde step which has ended continuity of care and the transmission of information about the patient. Although country-wide in its effect, no-one knows from where this decision 'through some strange alchemy', originated. Outside the main centres, consultant psychiatrists are passive and cowed, adopting the same rule-based processes used by management instead of clinical intelligence based on evidence. This is why the undoubted advances being made in mental health research are not being put into practice. It is what Atul Gawande in the 2015 Reith Lecture called 'ineptitude', that knowledge exists but individuals fail to apply that knowledge correctly. Because the individuals, consultants, have no power: the power lies with managers.

In our NHS, management is increasingly dominating the direction of its activity, away from health needs as they exist, towards income generation, whether the Tories' privatisation plans go ahead or the 2012 Act is struck down. No account is taken of patients' needs, the patients' collective voice which reached its zenith in the 90's with Community Health Councils, has almost disappeared. Trusts' websites are replete with 'mission statements' and their pictures of their personnel but in mental health services at least, give little information on how the ordinary person might access their service.

All this could change, with little reorganisation. It needs Aneurin Bevan's purpose of 1946, the NHS as meeting real health needs, to be carried out by expert clinicians. Clinicians and patients should determine health needs: the structure through which they operate and deliver, would revert to expert administrators, who would be expressly forbidden from straying into clinical matters, but would be as defined: 'persons responsible for carrying out the administration of ... the organisation' (COED). No longer should management be able to employ, at great expense, external 'consultants', in place of Consultants.

Richard Symonds

1. The Transatlantic Trade and Investment Treaty which is to be negotiated between the USA and the European Union.
2. 'On the phenomenon of bullshit jobs' 21-08-2013 in 'Occupy' magazine – originally in 'Strike!' magazine.

Prescribing in Tongues
(Lingua obscura? Speak English!)

There is a persistent urban rumour that to qualify in medicine it is necessary to speak Latin. It was never true, so where did the idea come from? In the past doctors were largely recruited from private and grammar schools, where Latin was certainly taught. However, the main entry requirement for medical schools is good A Level grades, especially in the sciences.

Confusion probably arises for several reasons. Anatomical classification of body parts derives closely from the Latin, particularly muscles and nerves. Many jargon terms are of Latin origin, but are easily identified in a dictionary of abbreviations. PRN means 'as required', without saying what for; notoriously BID means both 'dosage twice daily' & 'brought in dead'. These antique terms should disappear in favour of plain precise English. Prescriptions traditionally start with the symbol R with a slash across its tail; this is variously interpreted as standing for 'recipe' or the Egyptian for 'take thou'. This does no real harm, but reinforces the suspicion that the profession is an occult conspiracy against the people.

Doctors' handwriting is infamously poor, which may lead to the mistaken belief that a script is in Latin. Certificates of qualifications may be printed in Latin, framed and displayed in offices. Recipients are unlikely to know what they mean, and must hope they are congratulatory rather than insulting!

Malcolm Bateson

This Changes Everything: Capitalism vs the Climate

Naomi Klein has written another blockbuster to follow her *No Logo: Taking Aim at the Brand Bullies* and *The Shock Doctrine: The Rise of Disaster Capitalism*. As is implied by the title, *This Changes Everything: Capitalism vs the Climate,* the book is a left of centre review of climate change. Like her other books, it is impressively researched and well written.

The most important message of the book is that, happily, the measures that we need to take to counter climate change are mainly measures that appeal on general grounds. For instance, we need to cut out damaging 'economic busyness' and find ways to assess social progress that avoid the misleading features of economic 'growth' (such as assessing the work caused by accidents and pollution as positive). Equally, we need to value activities that are valuable but ignored in assessments of GDP or GNP such as unpaid work in various kinds of caring. This fundamental section is worth quoting at length:

> *'A great deal of thought in recent years has gone into how reducing our use of material resources could be managed in ways that actually improve quality of life overall – what the French call 'selective degrowth'. Policies like luxury taxes could be put in place to discourage wasteful consumption. The money raised could be used to support those parts of our economies that are already low-carbon and therefore do not need to contract. Obviously a huge number of jobs would be created in the sectors that are part of the green transition – in mass transit, renewable energy, weatherization, and ecosystem restoration. And those sectors that are not governed by the drive for increased yearly profit (the public sector, coops, local businesses, nonprofits) would expand their share of overall economic activity, as would those sectors with minimal ecological impact (such as the caregiving professions, which tend to be occupied by women and people of color and are therefore underpaid). 'Expanding our economies in these directions has all sorts of advantages,' Tim Jackson, an economist at the University of Surrey and author of Prosperity Without Growth, has written. 'In the first place, the time spent by these professions directly improves the quality of our lives. Making them more and more efficient is not, after a certain point, actually desirable. What sense does it make to ask our teachers to teach ever bigger classes? Our doctors to treat more and more patients per hour?'*
>
> *'There could be other benefits too, like shorter work hours, in part to create more jobs, but also because overworked people have less time to engage in low-consumption activities like gardening and cooking (because they are just too busy)…If countries aimed for somewhere around three to four days a week, introduced gradually over a period of decades…it could offset much of the emissions growth projected through 2030 while improving quality of life.'*

The prospect of a society having 'spare potential work' is profoundly and encouragingly relevant to an NHS and social care system that are over-stretched.

I will end this short review with a specific topic that caught my eye, a comment about world disasters:

> *'Over the course of the 1970s, there were 660 reported disasters around the world, including droughts, floods, extreme temperature events, wildfires, and storms. In the 2000s there were 3,322 – a fivefold boost. That is a staggering increase in just over thirty years, and clearly global warming cannot be said to have 'caused' all of it. But the climate signal is also clear.'*

Peter Draper

The Shadow in the Dark Side

Journalists can be a descriptive bunch. They will willingly borrow metaphors to suit the purpose. Public relations (PR[1]) has long been subject to this, since around 1977 anyway: 'The Dark Side' is how many reporters refer to public relations and those who practise it. Straight from Star Wars. 'Crossing over to the Dark Side' is a common insult when referring to one of the increasing number of news-gatherers who have taken the plunge and gone into PR. It has connotations of surrendering integrity, selling out, peddling the corporate lie: doctors of spin, doctor. But, for health, it's a deal more serious than that. And there's a shadow in the Dark Side you should know about.

I learned the dark arts of PR as a senior press officer for Birmingham Children's Hospital. There can be few better places to learn about PR and the NHS than a children's hospital. Everyone wants a sick child to get better; no one wants to think about their worst possible nightmare as a parent. These are the threads from which news can be spun, and it was a joy to do that even when it was bad news I was spreading. Journalists, as a rule, will respect the 'PR' if you are honest and if you come back to them with more.

Often that wasn't easy. Many NHS staff fail to grasp how the same principles that guide them ethically can and should be applied to public relations for a hospital. But I won them over. The simple step of transforming the hospital magazine to one engaging staff and families with stories about…well, staff and families won over many. Handling the press professionally worked for more. Even managing global e-mail, a dire chore, persuaded some. PR, for that trust, did become what it should be – one aspect of a well-managed professional function of communications.

Then it started to change. Becoming an FT probably marked the first visible sign of the Shadow. Now we were expected to sell an idea: that everyone who had an interest in a children's hospital (which is almost anyone) had to be encouraged to become a 'member'. Of what? And what – other than another magazine, the right to attend some more meetings and a free Post-it pad – exactly did it mean? No one could answer that except in abstract terms: 'become part of the new democratisation of health'; 'share in the hospital's future'. Oh dear.

This was followed by yet more lengthening. Now there was talk of 'branding'; of 'marketing the services to outlying trusts'; and – the most damning of all – patients and families started to be replaced with 'customers' (though not, I have to add, by anyone actually treating them).

The growing sense that something was not as right only worsened with a change in Chief Exec. Structural change swiftly followed – and by then I didn't take much persuading. I took the money and ran.

To find out more. My Masters focused on the role of PR in the NHS: the ethics of it, in particular. What I found was both encouraging and worrying. NHS PRs are nearly always dedicated, professional and determined to act for the benefit of their organisation and the patients it cares for. They are unusual for PRs in having a clear ethical imperative: the needs of the patient are always the first loyalty. What drives them in making the conflicting decisions they are often saddled with can be described as a sense of ethics. They want to do right, and the most common way they have of gauging that is in judging what should be done along with the likely consequences of their actions: normative consequentialist ethics. Many were wary of an NHS framework attempting to define that, lest it become a tick-list of prescriptive behaviour and a way of assigning blame. But all of them said the complete absence of any kind of systematic support for taking decisions for PRs in the NHS made their roles harder, and more importantly made that role almost completely dependent on the relationship with the CEO. If the Chief understands the media and wants to promote openness, great. If not…

Yet these are the people who are meant to speak truth to power. These are the voices of the organisation. They are meant to have a professional conscience, and should reasonably expect their employer – post Francis – to at least recognise that. But that remains an open question.

Further work – with Dr John Lister and others

– placed what is happening in the wider context of health journalism. That too is undergoing changes for the worse: 'churnalism', where fewer journalists are expected to churn out more and more, leaving less and less time to check or even question. So on the one hand we have PRs in health organisations lacking the support they need to be open and transparent. And on the other, we have journalists who are less inclined to doubt them.

It is not difficult to see where this is leading. As NHS organisations become increasingly snared to the neoliberal trap, where branding and marketization are the ultimate intention, the ability of any PR with a conscience to stand and say no diminishes. Just as reporters – whose industry suffers the same blight – become less able to question what is being said. The Shadow is complete.

Only by opposing this can it be stopped. Which is why I chose to use my PR skills for campaigning. Shedding a little light can only help dispel the Shadow. I will never (re) join it.

Alan Taman
Communications and Media Officer, DFNHS
(and sci-fi geek)

1. An unfortunate abbreviation when it comes to health – but PR professionals are stuck with that too.

Early Medical Training: A Personal View

Having decided on medicine as a career I matriculated to Birmingham Medical School in October 1963 with 3 science 'A' Levels, some of whose content was duplicated in the preclinical years.

The first two terms of 2nd MB were intensive: 20 hours/week dissecting, practical histology at the microscope, and Saturday mornings for embryology, as well as lectures. We studied books late into most evenings. The next three terms were physiology, biochemistry and bacteriology. However, I developed glandular fever and lost a whole term's work (which proved easy to make up). There was also the only long vacation of the course, so that 6 months out of the year were lost to study.

After five terms we were delighted to start clinical medicine with a 6-week introductory course. Over the next 3 years we rotated round various clinical specialities as well as studying pharmacology, pathology and social medicine. It was clear that the best educational opportunities were on the wards and in the clinics, not in the library; though lectures and bookwork continued. Periods of residency, especially 3 months for obstetrics, were the best learning experience of all.

Come Final Year we were completely jaded, and attendance at lectures and even clinics fell off, as did reading. We eventually graduated adequately if not with distinction in June 1968. In retrospect our course could have been easily compressed into 4 years, perhaps starting in August and finishing in July, with 6 weeks holiday annually, as is usual in employment.

That still seems a good idea, even with different modern approaches to learning and assessment. Early introduction to clinical work is a better idea than sharply demarcated preclinical studies. Surely applied anatomy with models, prepared dissections and illustrative CT & MRI scans is all that is needed for basic training? Surgical technique is a different skill requiring live tissue for those specialising in it. Medical studies should avoid repeating 'A' Level biology and chemistry.

Now that the Pre-Registration Year has been replaced by two Foundation Years, not necessarily supervised directly by the original Medical School, it might be better for a first bachelor degree to be granted after 4 years, with independent practice allowed only after the Foundation Years. This could be supervised by the General Medical Council, perhaps with full registration being marked by the award of a national MD qualification.

Medical learning may be a lifelong experience, but could benefit from a shorter preamble.

Malcolm Bateson
Retired General Physician and Gastroenterologist

Labour and the Election

What Might Have Made a Difference. A Personal View.

1. The economy.

'Labour bankrupted the economy, the Tories rescued it and if Labour comes back into power there will be chaos'. This mantra was repeated each week without fail during Prime Minister's Question Time for the 5 years of the previous parliament. It was repeated innumerable times throughout the election campaign by Conservative spokespersons. Immediately after the election David Cameron spoke about having to correct 'Labour's four year recession' in the forthcoming parliament. The Big Lie repeated often enough becomes the accepted truth.

What was astonishing was that the mantra was not rebutted from the outset or subsequently. On one occasion during the electoral TV debates, Ed Miliband spoke about the international financial crisis having an effect on the Labour government's economic performance, but he did not go into any detail. As the Guardian's economics commentator William Keegan pointed out, Labour was not responsible for the American sub-prime crisis. Gordon Brown's appointment of teachers, doctors and nurses did not cause Lehman Brothers, the fourth largest investment bank in the US, to crash. The international consequences affected the UK more than other countries because the City of London is the largest financial centre in the world. Miliband was at the Treasury when approximately £1 trillion was used to bail out Northern Rock, RBS, Lloyds and other institutions and the amount delegated was voted through parliament by both Labour and Tories. Gordon Brown's handling of the financial crisis won widespread acclaim in the UK and abroad. In addition, the global recession following the collapse of Lehman Brothers had slashed UK treasury tax receipts by over £40 billion. Despite all this, when Gordon Brown left office, annual growth of the economy at 0.6 per cent was higher than it is now at 0.4 per cent which represents the so-called economic recovery after 4 years of austerity.

Keegan writes: 'It was the banking crisis: repeat the banking crisis'. Miliband might have pointed out that it was Mrs Thatcher who deregulated the UK banks in concert with Bill Clinton revoking the Glass-Steagall Act in 1999. This US Act had been passed in 1932 following the Great Depression of 1929 to prevent the very same bank speculation which led to the 2008 crash. At one of the electoral TV events Miliband was asked if he had had any regrets about Labour's handling of the economy. He spoke of not instituting bank regulation, but gave no further details to enlighten the audience. He might have pointed out that Mrs Thatcher was the distal cause of the banking crisis in the UK.

2. The NHS

Miliband did not remind the electorate of Cameron's infamous promise of 'no more top-down reorganisations of the NHS'. In his 2006 Conservative conference speech, he said: 'So I make this commitment to the NHS and all who work in it. No more pointless reorganisations'. Andrew Lansley in a Conservative Party press release of 11 July 2007 said there would be no top-down re-organisation. In a speech at the Royal College of Pathologists on 2 November 2009, Cameron said: 'With the Conservatives there will be no more of the tiresome, meddlesome, top-down re-structures that have dominated the last decade of the NHS.' Yet the then chief executive of NHS David Nicholson stated that the top-down reorganisation proposed immediately after the 2010 election was so big that it could be seen from outer space. The Health and Social Care bill was three times the length of the bill originally establishing the NHS in 1948.

Miliband should have repeatedly pointed out the deception of the electorate that occurred, that had the electorate been informed of what was coming that the 2010 electoral outcome might have been different. Of course a great deal more could have been said about the Tories handling of the NHS. The NHS was the issue about which the electorate trusted Labour most, yet Miliband's approach was muted. It was limited to saying that Labour would do better than the Tories and he spoke of increased numbers of doctors, nurses and midwives.

3. Miliband's presentation on TV

'Attack is the best form of defence' said George

Washington in 1775 during the American Revolution. Miliband's presentation on TV seemed to me to be restrained. He might have been advised to adopt a statesmanlike posture to counter the vitriolic, denigrating attacks in the right-wing press which identified him as unfit to lead. It is easy to be wise in retrospect, but I think he needed to have had a much more aggressive stance in general and in particular to have attacked Cameron. The misrepresentation about the economy, the deception about the NHS, the ludicrous linking of defence/Trident to the so-called stabbing of his brother in the back, scaremongering about the SNP having a post electoral arrangement with Labour, and so on, were issues to rightly challenge Cameron's integrity and judgement.

Morris Bernadt

Centre for Health and the Public Interest - CHPI

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