DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Will justice and fairness prevail?

The enduring cost of the Bawa-Garba case

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The cruel legacy of mammon

> **'No man can serve two masters, for either he will hate the one and love the other or else he will be devoted to the one and despise the other. You cannot serve God and wealth'**
>
> – Matthew 6,v 24

This well-known quotation about the conflict between God (or the good of all) and the pursuit of wealth is as true now as it was 2000 years ago. It is a matter of priorities.

The first duty of a private company is to increase its corporate earnings and maximise shareholder profits, while the priority of a publicly provided service is quite different.

The NHS is of course not alone in suffering from misguided outsourcing. In the part-privatisation of the probation service, offenders – many of them vulnerable – were no longer to be supervised by regular face-to-face contact but just by an occasional phone call or even, in some cases, by logging onto a computer program.

We have heard recently about the dire state of Birmingham prison, outsourced 5 years ago to G4S with the aim (quoted in *Private Eye*) of saving 23% of its running costs. G4S required a 20% profit margin too and so staff numbers were cut by a third to save money, with predictable consequences.

Training for London's fire brigade was outsourced to a private company by Boris Johnson, and this may well have been significant in the Grenfell tower tragedy. Privatisation of schools in the shape of academies has resulted in extremely well paid heads and leaders of academy chains, but very mixed results for children's learning, while frequently 'off-rolling' less able pupils to boost schools' results. This programme has also given away vast quantities of public assets. Yet more public assets will be lost under the Naylor report which advocates selling off up to £ 5.7 billion of NHS land and property even if it is currently in use, such as the Royal Free proposals to sell off affordable staff accommodation for development into luxury flats in London.

In 2015, the Conservative-led Northampton Council outsourced almost all its services to four private-sector service providers, transferring 4000 workers to their rolls and leaving only 150 council staff. The Council has just declared itself bankrupt and may be unable to provide even the statutory bare minimum of services. The excellent 'We Own It' website has information on these and many other outsourcing issues which affect virtually all public services (https://weownit.org.uk).

In the NHS, outsourcing continues. Virgin, we are told [1], has been awarded nearly £2 billion of NHS contracts in the last 5 years. It is now one of the largest healthcare providers, with about 400 contracts across England. It took court action when not awarded a contract for children's services in Surrey and this was settled for £2 million of public money. Health campaigners have long been concerned about PFI, when assets worth £57 billion are predicted to cost taxpayers £307 billion by 2049-50. Private companies can and do leave contracts early. The collapse of Carillion has left two large PFI hospitals in half- built limbo, with no clear plan to complete them and, in Liverpool, a worrying lack of maintenance of the old building. Capita, another large provider, has been criticised for the problems with a primary care support contract as it 'potentially compromised patient safety'.

Every public survey shows that private provision of NHS services is unpopular, though it is not easy for a patient to know a service is outsourced when it can use the 'NHS' logo. An estimated 50,000 people from across England joined the NHS march on June 30th, with thousands more at smaller events elsewhere, so there is widespread concern.

The business model for foundation trusts means that they too must concentrate on making a profit, or at least not too much of a loss. At the recent BMA ARM (See page 12), a survey showed that three-quarters of doctors felt that cost-cutting and financial targets were being prioritised ahead of patients' needs, with job losses and bed cuts. Many trusts have set up 'subcos', wholly owned companies to which they transfer most staff contracts. Pensions are affected, and new staff will be on less satisfactory terms of employment. This prioritisation of finance affects staff wellbeing and job satisfaction as well as patient care, but in spite of all the efforts to cut costs, NHS underfunding leaves 75-80% of acute trusts now in deficit.

In 2017 Greater Nottingham announced plans for the US insurer Cengene Corporation to play a large role in their proposed accountable care system. Such involvement would prioritise cost-cutting and restrict services.

What can we do? The NHS Reinstatement Bill was re-introduced to Parliament in July and is due for debate on October 26th (see page 15). This is absolutely vital and we must make sure our MPs understand this. The recent judicial review of plans for Accountable Care organisations (now termed 'integrated care'[2]), though not completely successful, has brought these plans to public notice and there is now a public consultation, to which we must contribute. We must encourage students and trainees to value the idea of public service and also educate them, as well as our colleagues, and indeed the public, about what is going on.

Continued campaigning has never been more essential.

References

1 Osborne, H. (2018) 'Virgin awarded almost £2bn of NHS contracts in the past five years' *Guardian* 5 August [online] Available at: https://bit.ly/2Kw3I4Z
2 Briefing summary available at: https://bit.ly/2MyoC3X

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Taking it to pieces: The perfect storm

'The NHS would be as safe as a pet hamster in the presence of a hungry python if Boris Johnson, Michael Gove and Iain Duncan Smith rose to power following Brexit.'

– Sir John Major, June 2016

'The NHS would cease to exist within 5 years of a Tory government.'

– Oliver Letwin, 2004

In 2005 Allyson Pollock's prophetic *NHS plc* [1] alerted us to the cunning and surreptitious way that the English NHS was being gradually undermined and the further steps which were being planned to do this.

Her prophesies have sadly been correct, and later books including *NHS SOS* [2], *NHS for Sale* [3] and *The Plot Against the NHS* [4] have shown us more detail about how alarmingly far this process has gone. Youssef El-Gingihy's short volume *How to Dismantle the NHS in 10 Easy Steps* ([5], with an updated edition due shortly) is a concise guide to this process. It is indeed terrifying to see how far we have been taken along this path.

Most of Dr El-Gingihy's '10 steps' have been in place for many years. We have had widespread outsourcing, first of non-clinical and, increasingly, of clinical services. Management consultants have been heavily involved in the plans, such as McKinsey's who played a large part in drawing up the infamous Health and Social Care Act (2012). PFI repayments, which must take priority over clinical needs, are an increasing burden on trusts, such as the huge interest repayments of over £100 million a year for Barts and the London hospitals. There has been constant media focus on NHS failures, while little is said about the financial and staffing pressures which caused them. Blame for failings is put on 'the ageing population' (even though this has been shown to be misleading[6]), on immigrants or on (largely imaginary) health tourism. Poor service by private providers is blamed on 'the NHS' – and indeed for the unfortunate patients concerned, that is what it is.

Where are we now? The penultimate step, 'the perfect storm', seems all too familiar. The austerity programme imposed in 2010 is thought to have caused much ill health and 120,000 extra deaths since then, and the UK increase of life expectancy has slowed more than in other wealthy countries except the USA. A recent report from Warwick University has shown a close correlation between 'leave' voting in the referendum and the effects of austerity such as the bedroom tax and welfare cuts. Without austerity, they estimated that 'remain' would have been a crucial 9.51% higher [7].

Austerity has been imposed on the NHS too. Even with constant 'cost improvements' and 'efficiency savings' there is a predicted funding gap of £22-30 billion by 2020-21. NHS beds in England, (including all types) have been halved over the last 30 years, with general acute beds falling by 43% since 1997-98, while growing numbers of patients are being treated. In 2014 the UK had around 2.3 acute beds per 1,000 inhabitants, compared to the EU-15 average of 3.7 acute beds per 1,000, but as Scotland has a higher figure the English level will be slightly lower. Bed occupancy in 2016-17 was 90.3% over the year and was often over 95% which is a dangerous level and leaves no spare capacity. In spite of this, many STP plans mandate further bed closures as well as the sale of valuable

public NHS assets such as land and buildings under the Naylor report.

Staff shortages are growing, with 32,260 vacancies in nursing and midwifery in September 2017. The loss of nursing bursaries caused a drop of 33% in applications and after the Brexit vote far fewer EU nurses now choose to work in the UK. A study by the Open University showed that 70% of nurses now leave the NHS within a year of qualifying.

Medical student numbers were cut slightly in 2010 though have now increased again, but shortages of doctors are widespread. In February 2018 the *Guardian* reported that 15.3% of GP posts are currently empty. The RCP 2017-18 census shows that 45% of advertised consultant physician posts are unfilled because of lack of suitable (or any) applicants.

'Breaking the allegiance and loyalty of staff is one of the important strategies for attacking a public sector organisation' according to Dr El-Gingihy – and that is going well.

The pay freeze has meant around a 20% pay cut for doctors and even the review body's rather meagre recommendation has been ignored. My recent final year student, now an F1 doctor, tells me her student loan adds up to £65,137, and would have been more if the university had not contributed £3000 of her fees in 1st and 2nd year as her parents' income was relatively low. She tells me that many students need to take part-time jobs in spite of the demands of their course. Once qualified, doctors often find they need to pay for compulsory courses during higher specialist training as many hospitals have cut study leave budgets. A recent SpR has had to spend £5000 of her own money on such courses in the last 3 years and this is not unusual.

Recent books such as Rachel Clarke's *Your Life in My Hands* [8] and Adam Kaye's *This is Going to Hurt* ([9] and see page 20) show the intensity of work for junior doctors and the pressures caused by deaneries' delays in telling doctors where they will be working or the last-minute issuing of rotas – things which surely could be avoided. Rota gaps are common; 68% of trainees in the 2018 RCP survey [10] said these occurred 'frequently' or 'often', with significant patient safety issues in 20% of cases. Job satisfaction in specialty training is generally good, but 59% of general internal medicine trainees in this survey would not have chosen GIM if they could begin again, 27% would take a job outside the NHS and 31% would have taken a job outside medicine. Rota gaps were a factor in the shameful treatment of Dr Bawa-Garba, a competent and conscientious paediatric trainee who was convicted of manslaughter and struck off after an honest mistake made in an impossible combination of circumstances. Fortunately, her appeal against the GMC decision has succeeded, though her criminal conviction remains at present (see page 8 for more).

> "Particularly in London... others are going straight into special training ... with a view to doing *entirely* private work."

Although most doctors remain strongly supportive of the NHS, a worrying recent development is that SpRs in some specialties, and possibly many more, are not going into NHS consultant posts on completing their training. Dermatology is an example. There are widespread consultant vacancies so they would have no trouble finding a post in a suitable area. Many do lucrative agency locums, either for the NHS or for private providers and may do so for a considerable time. Particularly in London, others are going straight into special training for laser treatments, cosmetic dermatology or Moh's surgery with a view to doing entirely private work. Consultants also band together as companies, either to do purely private work or to supply needed services, at an inflated

price, to NHS patients. When this happens they are not only damaging the NHS by failing to work in units which need them, but are also contributing nothing to teaching and training of students, GPs or future trainees.

Outsourcing of routine surgery also affects training as so many routine procedures are done in the private sector. These are mainly, because of cherry-picking, the uncomplicated patients which trainees need to see. As a result of this, and of bed shortages, the RCS is concerned that many SpRs are having trouble doing even the minimum number of operations to complete their log books.

An ever lengthening list of treatments of 'limited clinical effectiveness' means that numerous necessary procedures are either not commissioned at all or are subject to individual funding requests which are time-consuming and are all too often refused. Hernias which are not rapidly enlarging or strangulating have recently been added, as has surgery for carpal tunnel and Dupuytren's. Sussex STP will only consider referrals for hip replacement if there is 'uncontrolled, intense and persistent pain...for at least 6 months'. Female hirsutism, often severe and distressing, has long been listed, (though male to female transsexuals can be treated). The NHS is steadily becoming much less comprehensive, and doctors cannot, of course, be trained in treatments which are not done.

Waiting lists for routine surgery are increasing because of bed shortages, targets for this and for A&E waits have been dropped and even cancer treatment targets frequently missed. A recent *Daily Mail* article [11] stated that two-thirds of NHS hospitals now allow patients to pay about twice the usual NHS cost of hip, knee or cataract surgery in order to jump the queue.

The last and tenth step in Dr El-Gingihy's book is 'introduce universal private health insurance'. We are not there yet, but the suggestion cannot be far away unless our campaigns, particularly the NHS Bill (see page 15), succeed.

References

1 Pollock, A. (2005) *NHS plc*. London: Verso.
2 Davis, J. and Tallis, R. (eds) (2013) *NHS SOS*. London: Oneworld Publications.
3 Davis, J., Lister, J. and Wrigley, D. (2015) *NHS For Sale*. London: Merlin.
4 Leys, C. and Player, S. (2011) *The Plot Against the NHS*. Pontypool: Merlin Press.
5 El-Gingihy, Y. (2015) *How to Dismantle the NHS in Ten Easy Steps*. London: Zero Books.
6 Keep Our NHS Public (2015) Fact Sheet [online] Available at: https://bit.ly/2LwJbsg
7 Fetzer, T. (2018) Did Austerity Cause Brexit? [online] Available at: http://wrap.warwick.ac.uk/106313/
8 Clarke, R. (2017) *Your Life in My Hands*. London: Metro.
9 Kay, A. (2017) *This is Going to Hurt*. London: Picador.
10 Royal College of Physicians (2018) Focus on Physicians: 2017-18 census (UK consultants and higher speciality trainees) [online] Available at: https://bit.ly/2wnQkGB
11 Borland, S. (2018) 'Pay £15,000 to jump the queue for a hip operation on the NHS: Hospitals encourage patients to self-fund knee replacements and cataracts surgery' *Mail Online* 21 July [online] Available at: https://dailym.ai/2No4QV7

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A mess from the start

Dr Bawa -Garba's case and the underlying attitudes it illustrates remain a cause for deep concern for the profession and the public

The difficulties associated with medical gross negligence manslaughter have been aired in these pages and many others, in the past.

Dr Hadiza Bawa-Garba's saga has done nothing to clarify things and the sequelae have made all the surroundings a great deal less clear and predictable, and English law likes clarity and predictability for the sake of future outcomes if nothing else. By comparison Dr Adamako, the original gross negligence manslaughter prosecution (endo-tracheal tube disconnected and alarms turned off) exhibited crystal clarity; no external factors, just him and a dead patient, and no preceding cases to muddy the water.

Compare with Dr Bawa-Garba. Day 1 back from 14 months' maternity leave, no induction in a new posting, rota gaps (ie staff shortages), unfamiliar juniors, partially functioning IT and thus no timely lab results, agency nurses and an absent supervisor, mentor and guide. All the components of the holes in Reason's Swiss cheese were lining up, if not lined up. If we are to continue to make airline analogies, Dr Bawa-Garba's day would still be in the crew room waiting for almost everybody else to turn up. Sick patients (pH 7.0, lactate of 11) do not wait for everything to be in order before turning up in hospital and have to cared for by all the sub-optimal resources of our cash strapped health service. Dr BG would not have been complimented for saying I am not going out there, as would an airline pilot.

Lethal bedlam existed at the Leicester Royal Infirmary that day. The circumstances have been well rehearsed elsewhere. Pneumonia, sepsis, acidosis, background of Down's syndrome with a congenital cardiac defect does not give much room for manoeuvre.

Dr Bawa-Garba received no help from anyone whilst doing the job of two others. Nothing to flag up abnormal lab results speedily, no timely reporting of radiology. An absent boss 'teaching elsewhere'; the consultant led service was not operational in Leicester that day. When he did return and was informed of Jack and the abnormal results he is said to have noted them in his note book but did not seem to have said 'we had better go and see him' or even 'shall we go and see him?'. Jack's fate was becoming inevitable. Although Hadiza Bawa-Garba is castigated in court for not recognising the difference between acidosis from pneumonia and that from sepsis there is no great evidence that 'Sir' did any better. His contribution seems to have been to get her to write her reflective notes and to see Jack's parents himself, without her, afterwards, despite his minimal contribution on the day.

In her reflections she is likely to have thought about not countenancing sepsis sooner, not insisting on antibiotics being started sooner. She, very correctly, did not prescribe his enalapril but not prescribing it does not seem to have been sufficient. She probably did not comment on staff shortages, IT inadequacies, doing three jobs, no radiology opinion, absent supervisor and all the rest of it.

The Leicester Royal Infirmary's internal investigation seems to have recognised some of the deficiencies and concluded that there was no

single root cause and made 23 recommendations and 79 actions to be followed up. Dr Bawa-Garba continued to work conscientiously and faultlessly.

Then it all started to unravel. Inquest led to a police investigation. Initially this suggested no further action but somehow the sitting duck of Dr Habiza Bawa Garba came into their sights.

Although the trial jury was told later that her reflective learning notes were not to be taken into account, her notes recognised mistakes she had made. That is what reflective learning is all about. The Crown Prosecution Service and thence the jury recognised the extensive systems failures putting poor Dr Bawa-Garba in a vulnerable position but only to say her conduct was exceptionally bad despite this. Her fate was sealed. There could be no appeal.

She was guilty of not being at the peak performance on day 1 after her maternity leave, of not distinguishing between acidosis due to sepsis from that of pneumonia with or without gastroenteritis, not anticipating that antibiotics would not be given for 6 hours after prescription, not anticipating that someone would give enalapril, despite it not being prescribed and all when the reason for any of this was beyond her control and she was, at best, poorly if not negligently supervised and largely un-supervised.

> "Dr Bawa-Gaba received no help from anyone while doing the job of two others... the consultant led service was not operational that day."

The GMC said that no one convicted of gross negligence manslaughter could be safe as a practising paediatrician and erased her name, removed her training number and extinguished her practising certificate. It commented that the public could have no confidence in it if it did not do this. The Medical Practitioners Tribunal Service (MPTS), however, did a more detailed analysis, recognising the background factors and her good conduct before and afterwards and felt she was not unsafe on the grounds of a single error in difficult circumstances and that a year's suspension was sufficient. This, however, posed a problem. The MPTS cannot disagree with the law which had said she was guilty of a criminal offence. The GMC appealed and the court upheld its appeal, saying that the GMC's erasure should stand. By its very nature, being guilty of gross negligence manslaughter was such that her failings were truly exceptionally bad, notwithstanding the systems failures, and she should remain barred from further medical practice. With a glint of humanity she was, however, given leave to appeal.

Appeal she did and the Appeal Court thought differently. Erasure, it said, for a one-off mistake was too severe and the suspension suggested by the MPTS was correct. She had been neither deliberate nor reckless in her actions and apart from this episode had been of exemplary conduct and presented no continuing risk to the public.

Jack's family remains concerned and continues to want her head on a plate. Whether this reflects the GMC's view of public confidence remains for discussion. The GMC has said it will not appeal and has much on which to reflect. It clearly has the not too easy task of retaining public confidence that it is protecting patients and guiding doctors whilst doing so in a fair and equitable way. It hoped Dr Bawa-Garba would resume her training and career.

In parallel, the Williams Report into gross negligence manslaughter in healthcare [1] asks for improved consistency in the use of experts in court in cases of medical gross negligence manslaughter, improvements in local investigations including involvement of the CQC particularly in order that a proper assessment of systemic and human factors may be made. It also suggested

removal of the GMC's right to appeal against decisions of the MPTS but not vice versa. Williams commented that there was no evidence that the GMC used its power to appeal in an excessive way. It also feels that clarification is required as to what might lead to lack of confidence in a regulator and how this translates into practice. In the knowledge that a disproportionate number of ethnic and racial minority group practitioners are reported to the GMC, improved equality and diversity training for fitness to practise panels is ensured.

The GMC has expressed its disappointment in the report, in particular that it did not seek to protect in law doctors' reflective notes so fundamental to professionalism, training and learning and thus to patient safety. Further to all this, the GMC has commissioned a report into how cases of gross negligence manslaughter are initiated in healthcare and also into why some groups of medical practitioners seem to be over-represented in referral for investigation. All very sensible.

And does anybody come out well from this sad saga?

Habiza Bawa-Garba had a bad day as determined by the MPTS and has worked conscientiously since and hopefully recovered her career. Nothing would have been achieved by sending her to prison, probably well recognised by the original court. Sadly she now has a criminal conviction against her name with all the consequences for mortgages, loans, insurance etc which that will have. We can only hope that things now stay on course for her although sadly Jack's family seems to have an alternative view.

The Leicester Royal Infirmary came up with proposals to avoid lethal bedlam in the future. We hope it has all been implemented.

The MPTS got it right, recognising all the factors on that inauspicious day but unfortunately it had chosen to disagree with the court's decision.

And everybody else?

Well they all justified what they did for public confidence or the law.

Should it have happened? Almost certainly not. There will be an effect on recruitment, remember what happened to paediatric pathologists after van Velsen. Folk will be nervous of what to commit to their learning notes: hopefully some good outcomes from the commissioned reports will address this.

As on a previous occasion, police investigations are not an appropriate place to sort out this sort of thing, involving the multiple facets and systems, leading them, by ignoring some of it, inappropriately to a single person being hung out to dry. Dare we ask where was the jury in this? Is a lay jury of 12 the way to resolve what amounts to the complexities of professional standards? Was the Leicester Royal Infirmary in court saying 'stop a minute, a lot of this was our fault, we have not got enough money?' That may be too much to hope for.

Reference

1 Williams, N. (2018) *Gross Negligence Manslaughter in Healthcare (The Williams Report)*. Department of Health and Social Care [online] Available at: https://bit.ly/2sN7ADw

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Blowing the whistle

Concerned NHS staff should be able to raise the alarm in a way that does not mean immediate career blight: but how?

One of the ways tragedies like that defining the events that befell Dr Hadiza Bawa-Garba (see previous article) can be made more likely is a prevailing culture of fear, recrimination and silence made all the more poisonous by fears surrounding speaking out.

The problem with being a whistleblower is that all too often you draw fire, not reduce it. Georgina Halford-Hall, Founder and CEO of Whistleblowers UK, which she set up as a result of her experiences in blowing the whistle on a charity, is speaking on whistleblowing at this year's AGM (see page 27).

The *Freedom to Speak Up Review* [1] was produced in 2016 by Sir Robvert Francis, with the express 'aim to create the right conditions for NHS staff to speak up, share what works right across the NHS and get all organisations up to the standard of the best and provide redress when things go wrong in future.' All NHS Trusts were implored to adopt its recommendations.

Clearly, we've a way to go but the message is clear enough: if staff are genuinely encouraged to speak out when things go wrong, things will almost certainly go wrong less often as a direct result. This is reinforced by the call for all trusts to appoint a Freedom to Speak Up Guardian, with the explicit reponsibility of ensuring the principles described in the Review are upheld.

But as under-funding continues and pressures on staff increase, this is far from the experience of many.

The Care Quality Commission's National Guardian's Office [2] offers a bit more bite to the promising words of *Freedom to Speak Up*, 'with the remit to lead culture change in the NHS so that speaking up becomes business as usual' as well as support Guardians in their role.

Why, then, does the culture of fear all too often outweigh these mechanisms and principles, which all would surely agree can only be for the better? The most likely way of it is that, in conditions perpetually teetering on near-collapse, fuelled by an overarching ideology that can be best described as innately hostile to the principles of the NHS in promoting marketisation and the breaking apart of the NHS, good intentions and an honourable framework will never be enough. There are simply too many competing pressures acting on staff to make the culture change encouraging whistleblowing both easier and more expected.

The appointment of Guardians must be a step in the right direction. But until there is a political admission that the law itself needs to change (see page 15), any good work the Guardians do is very likely to be overshadowed by the grim realities of how marketising forces make working for the NHS far from secure and a deadly silence the greatest failure of all.

References

1 Francis, R. (2016) *Freedom to Speak Up: raising concerns (whistleblowing) polcy for the NHS*. NHS Improvement [online] Available at: https://bit.ly/2LVjcuA

2 Care and Quality Commission (2018) *National Guardians' Office* [online] Available at: https://bit.ly/2NcxjR6

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BMA Annual General Meeting ARM 2018: Key issues

The new Chair of Council Dr Chaand Nagpaul made a blistering speech against cuts and privatisation responsible for an all-year NHS crisis.

We passed motions condemning the lack of NHS funding, and unsafe working conditions; recognized the chronic lack of staff, and called for the introduction of safe staffing levels. We were concerned about doctors' stress and burnout and suicides and insisted that 'the Department of Health indemnify all doctors for the associated reduction in patient safety'. Motion13 called for 'government to stop blaming doctors for errors resulting from system failures', and to establish anonymous reporting systems for patient safety concerns, and the appointment of 'Freedom to Speak Up Guardians'.

Privatisation opposed

Agenda Committee motion (ACM)14 opposed insurance based healthcare systems in the UK and was overwhelmingly passed. London Regional Council had expected Allyson Pollock to move it, but remarkably she was denied admission to conference. Speaking in support, Mrs Anna Athow (AA) said Integrated Care Systems were the American model and worked on a risk share/ gain share basis incentivising profit from rationing hospital care (this system means that if there is any profit after providing services, commissioner and provider share the surplus between them: the provider has an incentive not to provide enough services, or risk providing sub-standard services).

Motion 19 called for the BMA to lobby NHSE 'to establish uniform criteria and a uniform process across the country for approving elective surgical procedures so as to abolish the present post code lottery.' The BMA thus endorsed a call for national rationing criteria for elective operations.

We voted again for the repeal of the 'competition regulations in the Health and Social Care Act' (Motion 26).

A curate's egg type motion, ACM37, called on the UK Government to confirm the NHS is based on the original principles of Bevan, and for adequate funds to meet patients needs, but (iv) – ' remove the strategy and administration of the NHS from direct political control' – was passed, despite claims that it was important to keep political control by parliament so that the electorate could influence health policy.

Representatives supported a call for increased taxation to fund the NHS (ACM38) and voted down demands for patient co-payments (ACM39). Consultant Kevin O Kane moved Motion 40 opposed to the Naylor plan of selling off NHS assets.

Government workforce policy was exposed as 'attempting to populate the workforce with alternatives to trained doctors in ACM43. (ii) said 'that the drastic shortage of doctors is dangerous to patients, as non-doctors were being put in the position of taking decisions they are not qualified to make,' and (v) called on the BMA to oppose the development and expansion of Medical Associate Professionals (MAPs) in place of trained doctors.' Mover AA said MAPs were being asked to do

doctors' work after 2 years training, and were not regulated. GP Terry John, said Physicians Associates are to see unsorted new patients and were taking funding away from GP training. (v) lost by one vote.

General practice

Dr Vautrey Chair of GPC listed the disastrous loss of practices, difficulties in attracting and retaining new GPs, and early retirement from stress and burnout. He said Dr Nigel Watson is leading a review to "re invigorate the primary care model".

The only person in 4 days to allude to the real government agenda for general practice was Dr Ainsley who moved Motion 67 calling for the protection of 'last man standing' GPs from the additional costs of resignation. He said 'The government plan some sort of end of independent contractor status. … with a new order of polyclinics or whatever they call them.'

There was a call for a cap on GP workload (Motion 65) and concern at the 'unacceptable barrier" of referral management systems which curtail GP-consultant referrals (Motion 66).

There was 'concern that the new online GP services are targeting healthy, less complex patients, the funding for whom is partly used to subsidise care for more complex patients on the registered lists.' (Motion 135). It called on the BMA (i) 'to demand a stop to the undermining of general practice by private companies who cherry pick the patients to whom they offer services.', and '(ii)to 'demand that online consultation schemes do not become established unless they are prepared to provide a comprehensive package for patients.' It then demanded more funds for GPs to do online consultations and innovate themselves.

Dr Katie Bramall said 'starting in April 2017 Babylon, in Hammersmith has now gained over 30,000 patients, half of them out of area and most aged 18 to 24. Every CCG in England funded a live video. She said 'the devil is in the detail, Patients not covered include those with chronic conditions, require ongoing medicines and home visits, or are pregnant. Meanwhile funding is lost to the original GP. We go bankrupt. This is disruptive technology.'

Worryingly, Motion 136 proposed that "in primary care it is no longer sustainable for the GP to be the sole data controller." It said that GPs feel highly exposed by the GDPR (General Data Protection Regulation Act). The ARM acquiesced to the 'BMA exploring' the possibility that commissioning health organisations (?CCGs, ACOs?AA) could have one data protection officer for all GP practices in their area! '

Anti-Brexit motion

A very anti-Brexit motion headed the International section. Dr John Chisholm painted a picture of imminent NHS demise in the event of Brexit. Speaking against, AA took the 'Tony Benn' view that the EU was a capitalist club, promoting privatization of public services – the stance of RMT, ASLEF and the Bakers Union in the referendum. She called for a united socialist states of Europe. All seven parts were passed, most with big majorities, but for (vii) ' oppose Brexit as a whole' 62% were For, and 38% Against.

Consultant contract

Dr Harwood, lead consultant contract negotiator, said the BMA had saved Local CEAs as a contractual right, and the new contract would be

fair, and not 'cost neutral'. Motion 88 proposed that full shift resident 24 hour rotas were difficult to sustain and suggested that resident night shifts for consultants over 50 were unreasonable. The proposer revealed that many consultants did not realize that Schedule3 paragraph 6 of the current contract, enabled them to refuse to work outside 7am to 7pm without mutual agreement. Accounts were given of the stress and ill health that can follow from years of night work.

Ballot for industrial action

The only motion which called for a ballot for action came at the eleventh hour of the last day. Motion 138 had demanding a real terms pay rise. Dr Peter Campbell, moved prioritized Motion 138e by NE Regional Council: 'That this meeting calls on the BMA to ballot for industrial action demanding;

(i) a real terms pay rise.

(ii) safe working conditions for all staff

(iii) an end to unnecessary assessment, appraisal and revalidation.'

He said that 'this step was necessary and dynamic' as pay was down around 20% for all crafts. There were unsafe working conditions – in a perpetual winter, with patients left without clerking and assessment for 24 hours in A&Es, provoking the letter from 62 A&E heads to Prime Minister May. 'We are simply describing and accepting the new normal. What is the alternative? Organise and that includes Industrial Action.' (IA) .

Seconder Dr Ridley said that 'under the DDRB proposal we will not get a real terms pay rise. We're supposed to plod on in unsafe conditions with rota gaps. We just want to pose the question. Do we want IA.?'

The vote was 41% For, and 59% Against.

Juniors' contract

Earlier, in the JD section, the main issues raised (Motions152-154.160) were lack of adequate training and supervision, the need to reflect openly and honestly without fear of recrimination, and more support for 'exception reporting' from Guardians of Safe Working. Motion 153 wanted key performance indicators to include adequate rest and sleep facilities, access to hot food 24/7, and rotas compliant with contract. The mover of Motion139 said the contract had 'had a negative impact on women and was unlawful. In 2004 the gender pay gap was 20% and now it is 40%.'

Bawa-Garba case

The case of Dr Bawa-Garba hung over the ARM. Three parts of ACM94 were passed. "That this meeting, in view of the widespread concerns about the adverse effects of the General Medical Council's actions in the Bawa-Garba case and its impact on NHS culture and morale: (i) declares that it has no confidence in the GMC as a professional regulatory body; (ii) demands an apology from the GMC over its handling of that case; (v)calls for a public inquiry to review the GMC's conduct in the Bawa-Garba case."

Motion 96 called for all appraisal information to be legally privileged. Motion 145, believed that 'an independent body should have a remit to provide confidential, professional, no-fault safety incident investigation on a par with the aviation industry.'

Anna Athow
Retired consultant surgeon
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The NHS Reinstatement Bill: back in the Commons?

The Campaign for the NHS Reinstatement Bill has been trying to find an MP to re-table the Bill in Parliament, since the previous version of the Bill that had been taken forward by Margaret Greenwood, Labour MP for Wirral West, fell when the 2017 general election was called.

We are pleased to report that Eleanor Smith, Labour MP for Wolverhampton South West – a former nurse and ex-President of Unison – approached the campaign and over the summer Eleanor has been working with the Bill's authors, Professor Allyson Pollock and Peter Roderick.

After a false start, and following meetings with Eleanor and a large meeting with Jon Ashworth, Labour's shadow health and social care minister, he and Eleanor signed up to We Own It's #NHS TakeBack pledge based on the NHS Reinstatement Bill, which now has 68 Labour MPs backing it (Figure 1). Eleanor then presented the NHS Bill in the House of Commons for its first reading as a 10-minute Rule Bill on 11 July 2018.

Figure 1

She was supported by 10 other Labour MPs (see Box 1) and Green MP Caroline Lucas who had tabled the first two versions of the Reinstatement Bill just before and just after the 2015 election.

Box 1: Labour MPs supporting the NHS Bill presented by Eleanor Smith

Bambos Charalambous – Enfield, Southgate
Jim Cunningham – Coventry South
Caroline Lucas – Brighton, Pavilion
Luke Pollard – Plymouth, Sutton and Devonport
Jo Platt – Leigh
Matt Western – Warwick and Leamington
Laura Smith – Crewe and Nantwich
Stephen Timms – East Ham
Thelma Walker – Colne Valley
Mohammad Yasin – Bedford
Dr Rupa Huq – Ealing Central and Acton

In her speech, Eleanor said:

"For decades, core NHS values have been undermined. I was a nurse for 40 years before entering Parliament and saw this first hand. I was also a member of Unison and fought against it. We might hear that there is no privatisation because the NHS remains free, but believe me, it is being privatised…. I left nursing and entered politics to fight for the NHS and to help to save it."

The second reading of the Bill has been scheduled for 26 October 2018. Unlike on previous occasions when the Bill was presented, only the long-title of the Bill was tabled on 11th July (see Box 2), and the full version of the Bill must be published in time for the second reading.

Box 2: long title of the NHS Bill presented by Eleanor Smith

"A Bill to re-establish the Secretary of State's legal duty as to the National Health Service in England and to make provision about the other duties of the Secretary of State in that regard; to make provision for establishing Integrated Health Boards and about the administration and accountability of the National Health Service in England; to make provision about ending private finance initiatives in the National Health Service in England; to exclude the National Health Service from international trade agreements; to repeal sections 38 and 39 of the Immigration Act 2014; and for connected purposes."

This is where the fun starts.

The good news is that Andrew Fisher, the Labour Party's Executive Director of Policy, has written to Professor Pollock saying that "we remain entirely comfortable with the thrust of the Bill", but they wish to consult on structures and on what should happen to public health and social care. According to Labour's National Policy Forum report published recently ahead of the forthcoming party conference:

> "A focus of the [Health and Social Care Policy] Commission in future will be to consult with and engage the whole Labour Party, **including trade unions representing NHS staff, on the appropriate structures for the future of the NHS. This will include how we restore our fully-funded, comprehensive, universal, publicly-provided and owned NHS without user charges, as per the NHS Bill (2016-17) [tabled by Margaret Greenwood MP]."**

More worrying is that Andrew wrote that "constraints of government and management of spending reviews and legislative programmes suggest to us that we may need to introduce promptly a Bill to enable the ending of private sector contracts and remove key provisions of the 2012 Act, such as the requirement for NHS to compete with private sector, and – only at a later stage in the first term, following consultations – to introduce our own structural reforms". This would be a timid and piecemeal approach.

But the immediate challenge between now and mid-October is for Labour to support Eleanor tabling a full version of her Bill, as close as possible to the version we have provided to her. A summary of it is in Box 3. The Bill's authors and Eleanor are due to have a further meeting on 10 September 2018 with Andrew's colleague Lachlan Stuart. If you have a Labour MP, please do what you can over the next few weeks to get them to support the full version of the Bill.

Peter Roderick
Co-author, NHS Reinstatement Bill
peterroderick@cjp.demon.co.uk

Box 3: A summary of the proposed NHS Reinstatement Bill as provided to Eleanor Smith

The Bill proposes to fully restore the NHS in England by 2021 as an accountable public service by reversing nearly 30 years of marketization, by abolishing the purchaser-provider split, ending contracting and re-establishing public bodies which plan and provide integrated services and accountable to local communities. The Bill gives flexibility in how it would be implemented, led by current bodies, including local authorities. It would:

- reinstate the government's duty to provide the key NHS services throughout England, including hospitals, medical and nursing services, primary care, mental health and community services,
- integrate health services under the Secretary of State, whilst allowing delegation of public health services to local authorities, and allowing for integration of social care services following and subject to further legislation,
- declare the NHS to be a "non-economic service of general interest" and "a service supplied in the exercise of governmental authority" so asserting the full competence of Parliament and the devolved bodies to legislate for the NHS without being trumped by EU competition law (for so long as the UK is an EU Member State) and the World Trade Organization's General Agreement on Trade in Services,
- exclude the NHS from international trade deals,
- require the NHS Commissioning Board (NHS England), clinical commissioning groups (CCGs), NHS trusts, NHS foundation trusts, and local authorities, including combined authorities and elected mayors, to develop a 'bottom up' process so that by 2021 services would be planned and provided without contracts through regional and local public bodies – which could cover more than one local authority area if there was local support, and taking into account English devolution – to be known as Strategic Integrated Health Boards and Local Integrated Health Boards,
- allow Health Boards to employ GPs, end pay beds and private practice in NHS hospitals and end contracts for GP services with commercial companies,
- abolish NHS England, CCGs, NHS trusts and NHS foundation trusts, following completion and approval by the Secretary of State of the Health Boards,
- repeal the competition and core marketization provisions of the 2012 Act, and abolish Monitor – the regulator of NHS foundation trusts, commercial companies and voluntary organisations,
- re-establish Community Health Councils to represent the interest of the public in the NHS,
- stop licence conditions taking effect which have been imposed by Monitor on NHS foundation trusts and that will have the effect of reducing by April 2016 the number of services that they currently have to provide,
- introduce a system for collective bargaining across the NHS,
- impose a duty on the Treasury to minimise, and if possible to end, the expenditure of public money on private finance initiatives in the NHS in England, and
- abolish the legal provisions passed in 2014 requiring certain immigrants to pay for NHS services.

Common cause – common fight

Health Campaigns Together and Keep Our NHS Public

The end of the summer "silly season" for news has brought a rapid-fire series of revelations and warnings on the state of the NHS after 8 brutal years of frozen funding, broken promises, intensified pressure to privatise service provision and increasingly vacuous rhetoric from ministers and NHS England alike.

They also underline why no organisation on its own is likely to command the breadth and depth of local and national support needed to defend the NHS against a variety of attacks, or press the case for the legislation we need to reverse the disastrous 2012 Health & Social Care Act, wind up the wasteful and chaotic market system in health care, bring privatised services back in house and stem the haemorrhage of cash from NHS into the pockets of private shareholders and offshore tax-dodgers through rip-off PFI contracts.

The past few days as this is written have seen clear signs of the problems in primary care, mental health services, the inadequate resources available for elective treatment, and the escalating pressures on emergency services that now apply year-round rather than just at winter time.

In primary care, the continued decline in numbers of GPs will only have surprised those naïve enough to have believed Jeremy Hunt's now infamous promise in 2015 to recruit another 5,000 GPs by 2020. But the problem is far worse than simply a decline in numbers, because the very concept of primary care as based on a GP's continuity of care with a defined list of patients has been effectively supplanted by NHS England schemes to merge GP practices into giant lists. We now have one "superpractice" covering 380,000 patients in the West Midlands, and plans to create "hubs" for primary care across the country.

Even more potentially damaging is the expansion from West London of the 'GP at Hand' online service in which an established GP practice has teamed up with private sector profit-seekers Babylon. A detailed analysis of this limited service – and its efforts to cherry pick the adults least likely to need any treatment, and its impact on other GP practices – has been published by *Pulse* magazine: its editor Jaimie Kaffash is sounding the alarm of the implications of this model, branding it "the true privatisation of general practice".

The fight against these fundamental challenges to general practice needs an alliance of GPs with professional bodies, trade unions, local and national politicians – and local campaigners.

Mental health services are another notorious area for broken ministerial promises, where Jeremy Hunt in 2017 also promised thousands of extra staff by 2021, although failing to explain where so many staff might be found or where the money would come from to pay them. The extra staff (which would only have replaced nursing staff lost since 2010) have not been delivered, while thousands of children and adolescent patients, and adults with acute mental health needs, are still being sent many miles on out of area placements due to a lack of local beds, despite Government pledges to eliminate the practice.

Ministers have again responded with empty rhetoric and cynical promises: but to mount a real challenge to this again an alliance needs to be built at national and local level – involving campaigners willing to put pressure on local CCGs and trusts.

The latest directive to NHS commissioners and providers calling on them to consider increased use of private providers in an effort to reduce waiting times for elective care comes amid reports that senior NHS managers have all but given up on meeting the 18-week target.

The policy is a desperate measure, since

treatment in private hospitals is likely to be available only at inflated "premium" prices, weakening the already serious financial deficits of trusts: and in any event the capacity of a small private sector (with small hospitals averaging just 50 beds) is seriously limited, and well short of the rising numbers of NHS patients. Waiting lists have grown by 300,000 since March this year.

The various furtive proposals to push through so-called "integrated care" systems that would effectively eliminate any real accountability to local people, need to be exposed, challenged and resisted by strong local as well as national campaigns. The fight to expand NHS hospital capacity to meet the levels of demand for elective care, rather than cut back and "reconfigure" services around the country also involves the fight for adequate and accessible A&E services.

In a service stretched and squeezed to the brink of disaster on so many fronts, there have been a number of specific local issues that have been coming to a head over the summer.

In Shrewsbury & Telford Hospitals there is fresh evidence of a massive systems failure in a damning CQC report of trust staff complaining patients were treated like "animals and cattle". There has also been evidence of a chronic failure to ensure safe care in maternity services, and news that exhausted and demoralised nursing staff have been walking away from the trust's crisis-ridden and "unsustainable" emergency services, raising concerns over patient safety.

All of these real problems – and many more – make a clear case for organisations to forge alliances and work together as far as possible to maximise impact. Keep Our NHS Public as the biggest network of campaigners, organised in local groups across England, has a vital role in keeping track of these changes and ensuring local resistance.

KONP itself also works as part of a wider fighting coalition, Health Campaigns Together, which since its launch early in 2016 has opened up new possibilities of working with trade unions, political parties, and all those willing to defend

the NHS. Together both organisations have been instrumental in building three massive national demonstrations, a large-scale conference last November, and many local events: we have helped delay and in some cases defeat reconfigurations, cuts and privatisation.

KONP and HCT value the support and involvement of Doctors for the NHS, and the experience, expertise, commitment and energy it brings: we can guarantee that any donation to either organisation will be well spent pursuing principles we share with DFNHS.

- Health Campaigns Together: www.healthcampaignstogether.com
- Keep Our NHS Public: www.keepournhspublic.com

John Lister
Co-chair KONP, Editor Health Campaigns Together newspaper
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Book Review

This is going to hurt. Secret diaries of a junior doctor
Adam Kay. Picador Press, 2017. 268 pp. £3.75 paperback (Kindle £3.38)

"This made me laugh out loud and cry in equal measures. Adam's book weaves in and out of his patients' lives and in so doing he tells, in a better narrative than I have ever seen before, of the pain and joy of working so close to despair, disease and death. It's a quite brilliant book".

– Clare Gerada

This is a 6 year diary of Adam Kay's life as a trainee in obstetrics and gynaecology. Comparatively early on in his career he seemed to be largely in charge of his work with the consultant available on the telephone, and so did ward rounds, outpatient clinics, complicated deliveries and ubiquitous caesarean sections. Blood and pus are interspersed with gallows humour and the style is informal and irreverent. One internet commentator wrote: "so I decided to read a couple of pages when I went to bed...ok, so I actually read for about three hours, it was a rather addictive read...slept for 5 hours then had to finish it and let you all know how brilliant this book is!"

Gaps in on-call rotas, often at the last minute, resulted in his staying for double shifts and he commonly worked a 90 hour week. On one occasion his phone woke him and it took him a while to realise that he was in his car in the hospital car park having falling asleep after the previous night's shift. He had forgotten to set his alarm, he was due on the labour ward, "and now they're wondering where the hell I am". It was Christmas morning. On another occasion on the way home from a night shift which included five caesareans, he was stopped by police "Did you know you just ran a red light, sir?" He didn't. Long hours and unexpected hospital demands had adverse effects on his relationship with his partner and more widely on his social life. He had dinner with his grandmother who after starters, licked her finger, wiped a dot of food off his cheek and licked her finger again. Too late he realised it had been a patient's vaginal blood on his cheek.

A Jehovah's Witness due for a myomectomy refused to consent to a blood transfusion and explained that if she received blood her family would never speak to her again. "Even more of an incentive to have a transfusion if you ask me". It turned out she didn't require a transfusion. Called to A&E to see a 19 year old who had performed her own labial reduction surgery and had cut three-quarters of the way down her left labium minus before she called (a) it a day, and (b) an ambulance. While carrying out a caesarean for a breech presentation, he discovered it was in fact a cephalic presentation. He afterwards informed the woman he had carried out a totally unnecessary caesarean, but it turned out she had actually wanted a caesarean. When he disclosed what had happened to his consultant, the consultant revealed that he had once performed an emergency caesarean, but when he got inside the abdomen, the baby had somehow delivered vaginally in the meantime.

His former school invites him to talk at a careers day and he speaks his mind, that doctors are "underappreciated, unsupported, disrespected and frequently physically endangered. But there's no better job in the world". He meets up with five past medical school friends in a bar to commiserate and share accounts of unfortunate experiences.

The last clinical entry is about a catastrophe involving a "lovely couple", recently married and having their first baby. As the caesarean drama developed his consultant came in and then another, the most experienced they could think of. Afterwards, "I start to write up my operation

notes but instead just cry for an hour". "Yes, I came back to work the next day …. but I was a different doctor – I couldn't risk anything bad ever happening again". Via the deanery he pauses his training, considers going into general practice and does some locum shifts, but after a few months hangs up his stethoscope. He takes up writing and script-editing comedy for television. On the evidence of this book, there is no doubt he can write.

The 2016 dispute arising from Jeremy Hunt's renegotiation of the junior doctor's contract rumbled on amidst the doctors' titanic struggle to meet patient need while furious at the injustice of worse terms and conditions of service and cuts to pay and pensions. He doesn't shy away from political comment and ends the book with an open letter to the secretary of state for health. Finally, there are two pages of acknowledgements to those who helped him produce the book, and the last sentence reads "With no thanks whatsoever to Jeremy Hunt".

Morris Bernadt

New 8-Page Leaflet

Doctors for the NHS is focusing on recruiting new members, in particular doctors in training.

A new 8-page, A5 promotional leaflet has been produced (selected pages shown) describing who we are, what we believe in and do – and how doctors can join.

If any member requires promotional material to give to colleagues please let Alan Taman know and we will send them a batch:

healthjournos@gmail.com

Christopher John Burns-Cox 1937-2018

This is the shortest precis of a very full life.

Chris was the son of an Anglican vicar and of a mother who was an accomplished musician and a woman of good works. He was much influenced in his youth by a farmer grandfather from a wealthy, Quaker, milling family. His hours at home in the vicarage garden nurtured a love of the natural world and let him dream.

His secondary education at Marlborough College was happy, leading to lasting friendships with pupils and some staff. He decided upon medicine, feeling he had the zeal of a missionary to relieve suffering. He entered Middlesex Medical School in 1955. He won prizes in cardiology and dissection. He observed that some patients got poor care due, he thought, to a Harley Street effect. He decided to avoid private practice. He was not appointed to a Middlesex 'house job' but went instead to Ipswich.

He married Pat, a radiographer in 1960, the wedding being conducted by Chris's father. The marriage was very happy. Three children were born. Pat supported him in all his works and travels.

His 'universality', with concern for all induced suffering and injustice, drew him abroad. The first was to British North Borneo, with Pat, and where their second child Nick was born. He did the lot there, including anaesthetics for his surgery. He developed preventative programmes to ensure mother and baby health, family planning, obstetrics, pathology, TB, and nutritional teaching. He liked a big challenge and served in about ten other countries, including St Helena.

He read and studied hungrily. He wrote many papers both from his tropical experiences and from his later work within our NHS. After a Senior Registrarship at Bristol Royal Infirmary, he was appointed to the well known Frenchay Hospital outside Bristol. He specialised in endocrine medicine with a focus on diabetes. He was loved for his drive to help his patients in all possible ways – foot care, keeping people informed properly etc. He would get a scheme afloat, and then cast off having inspired those who took the baton.

This included his altruistic donation of a kidney and the setting up of the charity 'Give a kidney'. For the last few years this was a large part of his life and in that time he changed the view of altruistic donation not only amongst the transplant service and medics but also amongst the public. He would have wanted any opportunity to publicise it.*

His drive to help the human condition, and for justice, lead to his work for the Palestinian people, including their suffering in Israeli gaols. He worked very hard for the life of our NHS and served on the committee of NHSCA. He joined the doctors who showed the subversion of due process following the unnatural death of Dr David Kelly, and especially in the unique absence of an inquest.

He succumbed to cancer of the pancreas a few months after having had a radical excision at the Queen Elizabeth Hospital, Birmingham. He was stoical in his dying and got messages of love out to family and friends.

If caring is the greatest human virtue, then Christopher had it in his marrow. He cared so much for so many things. We march on with help from his spirit.

David Halpin

*http://www.giveakidney.org

CONFERENCE and AGM 2018

Saturday 6th October

Unite House, 128 Theobalds Road
London

11 am to 5 pm
Evening meal

Speakers for 2018

- **Professor Allyson Pollock,** Consultant in Public Health Medicine and Director of the Institute of Health and Society at Newcastle University. Long-standing member and former DFNHS Chair. Co-author of the NHS Reinstatement Bill.
- **Dr Ben White,** Doctor in Training in Gastroenterology. Ben played a prominent role in the judicial review challenging the imposition of the junior doctors' contract and in the JR4NHS campaign.
- **Georgina Halford-Hall,** Founder and CEO of Whistleblowers UK, which she set up as a result of her experiences in blowing the whistle on a charity.
- **Paul Noone Memorial Lecture: Dr Chaand Nagpaul,** Chair of the BMA, who has brought a greater sense of urgency to the BMA's criticism of health policy.

Full details and application forms should be with members.
You can still book by contacting:
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Phone : 01295 750407
e-mail: nhsca@pop3.poptel.org.uk

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