DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

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View From The Chair: Past, present and future

When we are treating a patient, we need to consider not only their current problem, but also what has happened to them in the past, as well as considering the impact of any disease, or the treatment that we are proposing, potentially over the rest of their lifespan.

I was struck by a recent article in *New Scientist,* by science journalist, Richard Fisher, exploring the ability of human thought to travel between past, present and future, allowing us to use past experience to formulate detailed plans and assess their impact on the future [1]. He also considers why we so often neglect to use those faculties, instead becoming transfixed by the immediacy of the present, such as striving to meet short-term targets that get in the way of strategies offering much greater benefits in the long run.

This can be seen in corporations chasing profits now, at the expense of patient investment in their long-term productivity; the low level of importance we give to investing in the development and education of the upcoming generation and in the climate and biodiversity of the world that we will bequeath to them; and the reducing importance given to the place of old-age pensions in both public and private business. A host of factors conspire to prevent us from taking a long-term perspective, including an unwillingness to postpone gratification, the greater weight we attribute to information from the present, our reduced sensitivity to gradual change, as well as the way our thoughts and behaviour are constrained by our culture and language.

It is essential that we overcome these psychological barriers if we are ever going to give the NHS any chance of playing its full role in reducing the toll that ill health takes on the wellbeing and productiveness of our nations. Phil Whitaker, in this newsletter, describes vividly the impact of insufficient workforce in primary care on the morale of those who are striving to maintain the standard of care available to their patients. Calls for a properly funded workforce plan for the NHS have never been louder. Such cries came loudly from Jeremy Hunt last year, when he was Chair of the Commons Health Committee, but now that he is in a position to deliver such a plan, we are met with silence. Nobody expects a plan that would solve every problem overnight, but an independently verified assessment of the gaps between the staff that we have, and what is required to provide safe, effective and timely care, together with the funding required to make good the current deficit while taking into account the impact of retirement from an ageing workforce, would send a strong signal of long-term commitment to the NHS and to its beleaguered clinicians to hold on – the cavalry is on its way. Its absence suggests the numbers, both of missing staff and the cost of training to fill the gaps, are just too scary to admit and, although it might be the right thing to do for the people of this land, the impact would not be felt sufficiently within this parliamentary term for it to be beneficial at the ballot box. Let somebody else deal with it, later, just like social care.

Even more fundamentally, there has been no vision set out for the long-term future for the health and social care of our population. Where do we want to be in 20 or 30 years' time? If we don't know where we want to get to, how can we decide how to get there? The best we have managed is a clutch of 'Five Year Forward Views' and

even those have been delayed and diluted in their implementation, or shelved. This doesn't provide a firm foundation for the long-term investment in rebuilding the missing highly trained clinicians, and neither the buildings, nor the equipment necessary to work to their full potential. Many of us harbour a strong suspicion that the aim is to preside over managed decline of the NHS up to the point that the public would accept a system in which for-profit organisations play the major part. However, the recently published British Social Attitudes Survey carried out in 2022 suggests that the public hasn't reached that point yet. Amongst the key findings reported by The King's Fund:

> **"As in 2021, a large majority of respondents agreed that the founding principles of the NHS should 'definitely' or 'probably' apply in 2022: that the NHS should be free of charge when you need it (93 per cent), the NHS should primarily be funded through taxes (82 per cent) and the NHS should be available to everyone (84 per cent)." [2]**

There were some suggestions of some weakening of the principle of funding through general taxation in younger age groups. Might this be an early sign of the 'shifting baseline syndrome' described by Richard Fisher as a response to changes that occur gradually, in this case, as memories fade of the experiences of so many people before the establishment of the NHS?

I never knew my grandmother. She died in 1942, 13 years before I was born and 6 years before the NHS was launched. She died from ovarian cancer, and she died in agony, because the family could not afford any painkilling drugs or dressings, or medical treatment. Her daughter, my aunt, had to leave her job and leave her husband so that she could do her best to nurse her mother as she died, because they could not afford to pay for a nurse, or for her to go into hospital. But that was very common in those days. Hundreds of thousands of people, up and down the country, shared similar circumstances, as Harry Leslie Smith remembered in his memoir, *Don't let my past be your future* [3]. We must not allow those memories to die.

This issue of the newsletter reflects the concerns about the precarious nature of primary care services that put it among the top of the public's priorities, judging by the British Social Attitudes Survey. David Zigmond's article implores us not to discard our accumulated past experience, but to use it appropriately in designing future services. It isn't a matter of turning back the clock: it is a matter of recognising the value of ways of working that are fast disappearing and incorporating them with the best of current ways of working. In particular, he asks us to pay attention to the importance of continuity of care in providing safe, efficient, personal and humane healthcare in general practice.

It was welcome to see this expressed in Dr Claire Fuller's report to NHS England on general practice last year [4] although the steps required to make this achievable have not yet made their way into the commissioning process. He also emphasises the strength of strong stable teams made up of people who understand each other's abilities and limitations in providing mutual support and fostering a good working environment in which people feel valued as individuals. Both continuity of care and appreciation of the importance of teamwork are also highly relevant to many areas of hospital medicine, even if they are often insufficiently valued when budget cuts come to be delivered. We know the value that our patients attach to the person-to-person aspects of the care they receive and we also know the difference it makes to our enjoyment of the work we perform.

The latest British Social Attitudes Survey may be disappointing in showing the lowest level of public satisfaction with the NHS since the survey began, in 1983, but it also showed that the public has a pretty good grasp of the factors underlying this poor performance, with understaffing and underfunding being major contributors. They still hold a belief in the original model of the NHS. In the light of the continued strong public support

for the founding principles of the NHS, shouldn't we be demanding that those seeking our vote in the run-up to the next general election make a clear declaration as to whether they agree to uphold those principles and how they are going to maintain them in practice for the decades to come? Along with universal access to high-quality education, access to high-quality healthcare is too important to the present and future prosperity of this country for it to be allowed to wither away.

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New Statesman's GP: The persistence of hope and the critical need for continuity of care

Phil Whitaker works as a GP in Bath and North-East Somerset, and has been a partner since 2001. He trained in Nottingham. Drawn to both literature and medicine, he started writing fiction as a student and now writes extensively (https://bit.ly/3Fv8Yjx). He started writing his column in *New Statesman* over 8 years ago and is now its Medical Editor (you can read his latest article on the fate of the NHS (https://bit.ly/3lfml0l).

Interviewed by Alan Taman

The changes in general practice

'We're a small practice, about 5,200 patients and three partners. Very much the traditional practice. I always aspire to continuity of care. I've seen lots of changes in general practice in my time, lots of push from government to 'work at scale' as they call it and prioritise instant access and not prioritise continuity of care and not appreciate what comes out of smaller scale practices.

'Our practice tries to preserve what it used to be. When I started out in general practice, personal lists were common and continuity of care was ubiquitous. We were always a primary healthcare team, with practice nurses, district nurses etc, there was no sense that doctors tried to do everything, but nevertheless patients had reasonably easy access to a very well trained expert medical generalist who could assess efficiently and holistically their problem. Then if there were other people who were going to be better placed to help them we could refer and arrange.

'But essentially the trend over the course of my career has been for practices getting bigger and bigger. There's no evidence that that provides a better experience and there's plenty of evidence to suggest that provides a worse patient experience. Continuity is declining year on year. The annual GP-patient survey by Ipsos Mori asks patients whether they have a doctor they recognise as 'their' doctor and how often can they get to see them. A marker of continuity. The number of people saying they know who their doctor is has been declining, it dropped to below 50 per cent a couple of years ago and it's now dropped off a cliff, 38 per cent in the last survey.

'All the evidence says continuity of care is vital and that small practices give a better patient experience. Hard-core evidence that says continuity of care improves outcomes, improves costs, reduces mortality, reduces secondary care activity. Yet all the push from government policy, as well as from some people in the profession to be fair, has been the trend to go away from what actually works and what is of peak value to patients in the NHS.

'The healthcare team has changed a lot. In my practice we're still very doctor heavy and our patients get easy access to a doctor. But in an awful lot of practices now, your first layer of primary care will be nurse practitioners or increasingly paramedics who've moved into primary care. I must stress these are absolutely valued, well-trained professionals, but they're not trained as doctors and diagnosticians. They work to protocols. I'm not suggesting for a minute they can't do what they do but I think that the whole interface that a patient has with the health service's front door which is primary care has become very fractured, fragmented, complicated and difficult. People without general practitioner training inevitably are working to protocols. These are fine for relatively simple things but not when anything gets slightly

complicated, which human health is.

'The power of a GP is immense for both the patients and the health service because we can cut through protocols and come to individual plans with patients that give me the freedom to explain to patients that maybe we don't need to start treating your blood pressure with tablets at the moment, why don't we think of doing something different. We can come up with plans together that aren't guided by a protocol, they're guided by experience and the ability to explain, and listen to what patients value and we're losing that.

'Since 2010 the numbers of over 65's has gone up by about a third. The numbers of hospital doctors has gone up by a third. You've got lots more activity in the hospital sector because you've got lots more older people and lots more clinical capacity. In the same time, numbers of GPs have dropped down by about 8 per cent. So rather than going up 30 per cent which is what we should have had we're at least a third if not 40 per cent down on the numbers of GPs.

'The Tories went to the polls in 2015 saying they'd get an extra 5,000 GPs. They went to the polls in 2019 saying they'd get an extra 6,000 GPs. Actually they've presided over a decline in numbers. We're down probably about 8,000 on where they thought that they would like to be by 2024. That gap, the loss of general medical capacity in primary care, is being mopped up in part by other professionals such as paramedics. No one has ever gone to an election saying they were going to redesign what the front door to the NHS looks like. But we're in an experiment in this country where the front door is no longer your doctor. The front door is a system, a point of contact. You might get assessed by a non-clinical call handler at 111 wielding a bit of software. Or by a paramedic or a nurse practitioner. Or by a GP but there's such fragmentation. That is worse for patients. The experience is worse and so are the outcomes. I think it's worse for the system itself.

'Out of hours has been changing like that since the 2004 contract and the pace increased in 2010 when NHS 111 came on stream. Out of hours has become unrecognisable, it's an horrendous experience for most people most of the time. That's starting to happen in daytime general practice with the loss of GP capacity.'

> "We can come up with plans together that aren't guided by a protocol, they're guided by experience ... and listen to what patients value and we're losing that ."

'We've got a good PCN. A long history of working together as practices. We welcome colleagues recruited via the ARRS [Additional Roles Reimbursement Scheme]. We share quite similar visions. We're all concerned about loss of continuity of care and difficulty of recruiting. I've got practices within my PCN who have been unable to fill GP posts and we've never had recruitment problems until the last few years. We do feel enthusiastic about being a PCN and what we can do in terms of expanding quality but very concerned about dwindling medical capacity and what that means for our patients.

'The perception of bigger scale offering more choice has some elements of truth in it. But an awful lot that isn't. Out of these expanding roles we've got clinical pharmacists who are great. They reduce doctor workload and increase quality, because they've got time to do really thorough medication reviews where GPs don't have the time to do those as thoroughly. But they don't reduce workload by the amount that might have been hoped. They're expanding quality.

'We've got care coordinators. In circumstances where I've got an older patient whose domestic situation is falling apart I've got someone who can pick up the ball and sort out care packages

and the like. That probably saves me a bit of time. We don't have a first contact physiotherapist yet but I heard one talking at our PCN recently who said he'd completely changed his understanding of what GPs do since starting in the role. He used to see patients via a GP and was now seeing patients with all kinds of undifferentiated problems.

'I think there are good things in that expansion of roles. But the problem is it's not being driven by trials and evidence saying where's the balance point, where's the optimum. It's being driven by a failure to keep the medical capacity up in primary care. Because it's starved of funding and is no longer attractive. But instead of addressing that, the political solution is to bring in other people which is unevidenced, unresearched. It's a huge experiment being conducted on the English public certainly. An experiment driven by failure to invest.'

'If you try to think about which patients would most require expert generalist medical care that would be your very elderly, multi-morbid patients. The worst of those would be house bound because they're so poorly. In many parts of the country this is the part of the population who can't get to see a GP, because the home-visiting services are now staffed by paramedics who are brilliant at handling acute medical cases or deciding if it's a hospital case or not, but their training and their character is not geared towards holistic, complex medical care. This is crazy. Nobody is looking at this. The very people who most need a good, experienced GP can hardly get that any more. Yes, the paramedics will go and will then liaise with a GP but it's not what I want for my mother, it's not what I want for myself when I get elderly. I do not want to have to battle through that.

Industrialisation of healthcare

'This is the idea that healthcare can be reduced to guidelines and protocols you can just slot patients into and then they churn along a pathway and they pop out the other end, and you haven't needed experienced professionals to take judgements and work with patients on individual decisions about their own health. This drives me crazy. I see adverts from NHS England essentially saying "'if something in your body doesn't feel quite right it could be cancer – go to your doctor and tests could put your mind at rest''. This is creating ever more anxiety about health and creating the idea that you've got to have tests and investigations.

> "This is part of the picture ... of driving up demand from worried-well people. Doing lots of stuff ... without much evidence that it makes much difference to outcomes ."

'A lot of charities are also driving this and so are a lot of patient groups. This is part of the picture we see of driving up demand from worried-well people. Doing lots of stuff for patients without much evidence that it makes much difference to outcomes. Primary care and increasingly secondary care is getting clogged up with processing lots of this kind of activity.

'Take PSA as an example. The view that everybody over say 50 should get a PSA done means a huge amount of testing. Yet most raised PSAs will not reflect prostate cancer and of those that do not all will represent cancers that are going to cause clinical disease in that patient's lifetime. So the demand for PSA testing is driving a huge amount of health service activity: blood tests and referrals, biopsies, scans, treatment with significant side effects. The industrialised vision of healthcare dictates that you have to go for a PSA test, then must be referred, then have a scan and then have to worry about treatment or waiting.

'But if you hear the same message about

prostate cancer and go along to your GP whom you have known for many years and who has had some great judgement calls about stuff in the past, and he or she then points out what the current data says, which is that screening is likely to cause more harm than good, but it's your choice. My experience says some men will probably want to go forward with screening but the majority in that circumstance won't. Because they get a proper, informed consent discussion with someone who knows them and they know and trust.

'There are many more examples. If you just drop it into industrialised medicine and take out the relationship and the shared decision making and the seeking of informed consent you will just drive up health service cost and activity for very little gain, if any.

'Whereas if you give sufficient capacity in general practice with continuity of care, you encourage a culture not of mass medication but of individualised decision making with a health professional. That will decrease activity – that's what all the evidence and my experience says. But we're eroding the capacity of the health service to do that kind of care. There's this idea you can just drop people in at one end of the pathway and they can just trundle along until the end. We could do a totally different job. But that takes time and expertise, it's complex.

'We have a menage a trois in general practice, where the government has come into general practice, and set lots of targets, which skews medical practice. We've all got targets on our shoulder. We've got financial incentives to turn in this percentage of people taking that medication or having that test done, or whatever. That is a powerful counter-force against the doctor-patient relationship being individual and tailored and informed, which is what it should be.

Recruitment and retention

Phil has a frank and bleak view of how all these changes in general practice are affecting recruitment and retention:

'They're going. Twenty one per cent of doctors under 30 who have gone into general practice left it last year. It's a difficult thing to say, but I wouldn't encourage anyone to enter general practice unless it turns around. Being a GP I think is the best job ever, but we're less able to do that job in the NHS. We're hanging on in our practice but I think in an awful lot of practices you can't do that job any more. Unless someone changes the landscape politically and allows us to get back to what we've all trained to do I wouldn't encourage anyone in. People are voting with their feet. About 1 in 10 of doctors over 55 left last year as well. The lowest cohort to leave are in the 40-55 age group, they're the ones mortgaged to the hilt and with kids at school and university. Essentially, I'm sorry to say this but people who have got the option are going. That's because the job is not what they trained to do, it's not what they want to do, it's becoming soul destroying. People who've got options are going elsewhere.'

The future of general practice

'I am still hopeful! First, it seems likely to me that we will consign the Conservative party to the political naughty step for the next decade in 2024. Also Wes Streeting seems to be moving in his views about general practice and listening. He recently said you can do three things with primary care: you can carry on letting it fall apart, or you can do a whole-scale restructure (to a salaried service), or you can decide that the traditional partnership model has great benefits to the NHS and to patients, in which case you invest in it and rebuild it. He added that the only thing Labour are not going to do is the first one. What his policy will eventually be I am not sure, but he has recognised that good primary care is both crucial and is falling apart and he is going to do something to rebuild it.

'I still don't think that enough people understand how critical GPs are to patients and to the NHS. I try and find ways to explain it to people. The best at the moment is if you think of the NHS

as a football team. My fantastic esteemed hospital colleagues are like the strikers and to an extent like the brilliant goalkeepers. So if you get someone who doesn't know anything about football managing the team they will probably think they need to spend all the money on strikers to score more goals. They continue to lose matches – so they spend more money on a brilliant goalkeeper. But they don't look at the mid-field. Where the players don't score goals and they don't make amazing dramatic saves but they make the whole team work. Because they feed the strikers with the balls to score gaols and stop lots of balls so the goalkeeper only has to do his job every now and then.

'People often talk of GPs as gatekeepers to the NHS as if the NHS were 'over there' and we let people through who need the NHS. But actually we are the NHS. We do 90 per cent of the healthcare. We call in our consultant colleagues when their expertise is needed. That means they are not swamped and it means the patients coming to them are pre-selected. The patient is quite likely to have significant organic pathology – they don't see huge numbers of people with less serious conditions. So their tests and opinions work well because of what I do. And I protect lots of patients from going forward who don't need to. But most politicians don't understand why GPs are so crucial.

A National Care Service

'The need for a national care service has certainly been mooted politically by Labour. The golden egg that everybody would like to see is health and social care operated out of the same silo. That feels like the destination we need to get to. A national health and care service where the goals are aligned. I would love to be able to look after and support in their own homes patients who at the moment end up rushing into hospital because there isn't sufficient care capacity. The budgets are all unaligned so social care gets cut

because it's local authority broadly speaking. Hospital budgets get protected because they are hospitals and they get paid by their activity. Primary care get block contract budgets and they ever dwindle. Everything's out of synch so by default as social care budgets get chopped and primary care budgets get chopped the healthcare needs go into the secondary care sector where they get paid by their activity, so all the money gets sucked into secondary care.

'Where we need to get to is somewhere where the whole system is all out for the same goal, which is supporting people in the right place commensurate with their circumstances.'

Integrated Care Boards

'I think it's a bit early to say about these. The only thoughts I have about them is about pendulums! When I started in the NHS there was the Regional Health Authority, which pretty much called the shots. Then there were area health authorities, which were a bit like the PCT/CCG bit. We were then swinging the pendulum towards fundholding, right down to the small level, with the GP practice calling the commissioning shots. Then everyone said "that's terrible" and we went to practice-based commissioning, which was getting slighter bigger scale, and then CCGs. Then CCGs amalgamated and now we're going to ICBs. We're going back up to larger scale.

'At some point in time someone will decide

that's really unresponsive to local needs and say the solution to that is to go smaller again, and we'll get some other iteration which is down at the level of the practice or the PCN. I'm slightly cynical about all the restructurings. I think it's too early to say whether an ICB will achieve that amalgamation of services. I think it's got to be bigger scale structurally. Whilst central government controls what the GP contract looks like, for example, I think ICBs are working in a constrained environment. My suspicion is they won't be able to achieve what they might want to achieve, because they're constrained by nationally controlled determinants. And that's without even starting to consider how to tackle the social determinants of health and health inequality.

Private medicine

'It's always been the case that GPs working in the NHS couldn't treat their own patients privately. But there will always be private medicine. There always used to be private GPs in London and one or two elsewhere but now they are virtually everywhere. The reason for that is because of the demise of NHS general practice. People who have got the money are voting with their feet. What patients want to do is book easily an appointment with a doctor. They can't do that in the current NHS. Private GP services are expanding. That is an indicator of the failure to provide good healthcare on the NHS.

'Back in 2005 I remember the private medicine industry was having kittens because the NHS was so good. Access to GPs was fantastic. If I wanted a scan or a 'scope I could get it within 6 weeks guaranteed. If I needed to refer they would be seen in outpatients within 6 weeks and if they needed treatment that would happen within 18 weeks from point of referral. I remember private insurance companies launching products that would kick in only if the NHS didn't meet those timescales. They devised these policies because nobody was buying insurance products any more. This was Blair's and Brown's insight, to make public services as good as the private sector. Then there would be no need for the middle classes to go private, they would stay in the public services. Then you had services that were good for everybody. They recognised that if you made public services as poor as they are now, the middle classes will go. They will vote with their feet and their cheque book and they'll carry on getting the kind of services that they can pay for and that everybody wants, but the people left behind get this rump 'Medicare' sub-standard, which is what we're seeing the NHS turning into.

> "They should measure their success by the shrinkage of the private sector and the reinvigoration of public services. That's how you get good healthcare ... for everybody."

'So for a Labour government coming in, if it's going to be a Labour government, their yardsticks for success should be year on year the dwindling number and eventual extinction of food banks, the dwindling number and eventual extinction of private general practice, and the dwindling demand for private schools. They should measure their success by the shrinkage of the private sector and the reinvigoration of public services. That's how you get good healthcare and education for everybody, by making it good enough that those with the money don't see the need to go private, apart from the few.'

Public awareness

'I started writing about what was happening to general practice and primary care back in about 2018. From about 2015 we were starting to see practices falling over and closing, and patients not being able to access a GP in certain parts of the country. Covid hasn't caused a new crisis, what it

has done is brought forward the crisis that was going to be coming in a few years. Then general practice got the absolute blow-torch from the *Daily Mail* and the *Daily Telegraph*. That media narrative which was tacitly joined by Johnson and Javid started out painting GPs as the problem, but I think there has been quite a successful turning of that narrative. There will always be people who will sign up to that narrative but I think more of the public are recognising that it is underfunding. The conscious demise of what I would call good general practice under the Conservative administration. I think the public is recognising now that there aren't the number of doctors because the service hasn't been invested in.

'I think the narrative is turning. I refer to the whole hospital crisis we've seen this winter as the canary in the coalmine. You get all the dramatic headlines, the ambulances stacked back. All that is saying is that social care has been allowed to demise – that's the back door problem – and primary care has been allowed to demise and that's the front door problem. If you look at all the people admitted to hospital, there will be some who will genuinely need hospital care, but the majority probably could have been managed at home if there was enough clinical capacity to do their care, and enough support capacity to support them. There's a lot of activity that goes on in hospitals that doesn't need to be there.

'And a lot of well patients who can't get back out because there isn't the support capacity. I think the public have got that as well. The social care bit is hard wired into public perception now. I'm trying to raise awareness of the front-door problem which is that the demise of primary care is pushing much more into hospital that doesn't need to be there.

- **Phil Whitaker's new book, *What is a Doctor?* will be out in July and will be reviewed in the next issue.**

Democracy and the NHS: A way forwards?

Work is what most of us do most during our waking hours, yet it is the realm of our lives that for the vast majority is democracy-free; this represents a global lack of enfranchisement (or perhaps even enslavement) on a gargantuan scale with dire consequences for all.

I, along with some of my colleagues on EC, have started to explore how more democracy at work could be proposed for the NHS. I have been greatly influenced by the work of Professor Isabelle Ferreras [1,2] and her colleague Amelia Horgan [3], and below is an overview of the importance of this principle for the NHS and for health generally.

Landmarks in the 100 years 'aspirational' history of democracy in and around Work

The International Labour Organisation was set up under the umbrella of and as a foundational part of the League of Nations in October 1919 thus ante-dating by a short time the League of Nations' foundation in 1920, itself the fore-runner of the United Nations which replaced it in1945.

The ILO Declaration of Philadelphia [4] on 10th May 1944 marked the 'resurrection' of the ILO towards the end of World War II:

'The Conference reaffirms the fundamental principles on which the Organization is based and, in particular, that:

1. (a) labour is not a commodity;
2. (b) freedom of expression and of association are essential to sustained progress;

(c) poverty anywhere constitutes a danger to prosperity everywhere;

(d) the war against want requires to be carried on with unrelenting vigour within each nation, and by continuous and concerted international effort in which the representatives of workers and employers, enjoying equal status with those of governments, join with them in free discussion and democratic decision with a view to the promotion of the common welfare.'

The disregard for the principles expressed in this declaration became so shockingly evident early during the pandemic, a group of female scholars were moved to write an OpEd for *Le Monde* that immediately became a manifesto and within months a global movement to Democratize Work [1-3] (and see the book review on page 29 which includes the proposal for a 'bicameral' model for democratising work [2]. I believe this would bring about great beneficial change if it could be adapted for our healthcare service).

A bold assertion

Full employment (including a Job Guarantee) with true democracy in and around work may be our only hope in the face of existential threats.

Why do I make such a sweeping claim?

The Evidence

Michael Marmot, in his Review [5] and the follow-up reviews [6,7] has presented incontrovertible evidence for the shameful fact that most ill-health is societal and avoidable; the fact that it continues is the result of political choice.

Marmot has also argued [8] that socio-economic position determines not only or not even mainly wealth, but rather something much more fundamental for our wellbeing: autonomy, being in control of our own lives. The psychological and overall health implications of this cannot be overstated.

But I would argue that it is not just individual health at stake. Can there be anything more determinant of 'status' than true democracy in and around work, after all it will directly impact on fairness in wages or salaries as well as everything else including what work is done, how it's done, and for whom it's done. If there was true democracy in and around work, that could mean that the thing most of us do most during waking hours as adults, work, would be performed by a working population who had brought their entire being to bear on what they do in the work they do.

Is it conceivable that with that ability to influence, people would then be in a position to make the choices which will result in the world being a better place to live? And would the NHS be a better place to work and do its job better if those who work in it were doing so in a way that allowed democratic principles to operate better? In 'Democratizing our NHS' I believe we would be going a long way to truly democratising our country. Success could then hardly go un-noticed.

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ho share these commitments.

A Time to Win

Johnbosco Nwogbo is the Lead campaigner for *We Own It*, which DFNHS has worked with on several campaign initiatives. *We Own It's* brief is wider than healthcare and the NHS, but they place fighting NHS privatisation and the continued undermining of the NHS as one of their priorities. Johnbosco is Nigerian, and campaigned successfully in the Fees Must Fall movement in South Africa (demanding better access to university for students from deprived backgrounds) before coming to the UK in 2017 to do a doctorate at the University of Sussex. He joined *We Own It* in 2020. Interviewed here by Alan Taman.

Can you outline what We Own It does?

'We Own It campaigns strategically to get wins, to map out campaigns to see what is possible given the current circumstances, being clear-eyed about the world we currently live in as opposed to the world we would like to live in. Then using the structures of that world and the political pressures which politicians feel, the conflicting interests all parties on any given issue will have, to put pressure on political leaders to do things.

'The most recent win of ours was getting the Culture Secretary to reverse Nadine Dorris's attempt to sell off Channel 4 to US interests. Last year we were able to get an amendment, despite the government's 80-seat majority, to the Health and Care Bill to make it more difficult for private companies to sit on the new ICS Boards [*DFNHS helped publicise this at the time*]. The specific way this is written is not exactly what we would have wanted, because it did not make this impossible, but it was much better than what existed before the start of the campaign.

'We've since obtained pledges from 11 ICS Board Chairs that private companies would not have a seat on their Board. We also persuaded Andy Burnham [*Mayor of Greater Manchester*] to bring buses in Manchester back into public control and one of my colleagues is continuing that campaign in several Northern cities. So it's all about getting wins in those particular issues.

'We care a great deal about our overarching goal, which is to take public services into ownership. But in the interim, given the political circumstances, we also care about getting wins where we can that move us in the direction we want to go.

What do you see as the main threats to the NHS?

The main threat right now are the huge waiting lists. They combine a host of political considerations that, without a force like us and DFNHS and others pushing from our direction, lends itself very conveniently to more privatisation within the NHS, with even the Labour Party speaking about why we need to use private capacity to deal with waiting lists. It's very difficult to argue against that and not look ideological because they will say 'people are suffering right now. You can't look at someone who is in constant pain and say to their face "I don't want you to use the private hospital that's available because I don't believe in privatisation" '. If you make that kind of argument you look ideological and people, especially those who don't understand the issues as well as we do, are going to think 'why is this person in favour of suffering?'.

'But the reality is that private hospitals don't have their own doctors and nurses, it's generally the same people as the NHS. They don't even have the vaunted excess capacity that is talked about. They want any capacity they have to treat private patients who pay out of pocket because that's how they make their money, and they make more from that than they make from NHS contracts. So in essence it's a non-starter to say that private companies should be used to deal with waiting lists. It's just not going to work. This just seems like an argument that is being made to normalise the role of the private healthcare system and I think there is a significant threat there.

'There is also the government's 'Elective

Recovery taskforce', which is filled with lobbyists for private healthcare. It's quite clear that they see the waiting lists as 'the gift that keeps on giving' and as an opportunity to encroach more into the NHS – that's where the dangers are right now.

How aware are the public about this?

'There are a few ways to think about this. A poll in late February [1] found that 66 per cent of the public said they were concerned about NHS privatisation. About the same number of people say that they wanted the NHS to be reinstated as a fully public service. I think the public understands that privatisation doesn't work for the NHS because private companies have a self-interest that is different from the interests of the NHS. Their goal is to make money. The NHS's goal is to cure people, to make sure they have wellbeing. They instinctively understand that those interests are a mismatch.

'The press do sometimes (but not always!) do a good job of telling the story. We saw a Panorama documentary last year that showed what Centene Operose were doing in the GP surgeries they took over in London [2] in 2017. They found that they were letting go of qualified GPs and hiring Physician Associates (PAs) in their place. PAs are not qualified GPs and they can't do the job of GPs. They did this essentially because it's cheaper.

'The public does understand this instinctively, that these kinds of companies don't care about the public they care about the money.

'At *We Own It* we say that popularity is one thing but salience is another. We draw the distinction by saying 'You might believe that the NHS should be fully publicly owned, but does that belief inform the way you vote when you step into the polling booth?'. That's the salience, the one issue that says to people 'this is the reason why I'm voting for this party as against voting for the other party'. At the last election it was Brexit, for the vast majority of people who voted Conservative. What we want to do at the next election is to make that issue the NHS. Not just highlighting the fact that we have such a long waiting list but making it clear that the role of private healthcare is part of the reason why there is such a crisis in the NHS. So when people step into the polling booth we want them to say to themselves 'Which party am I voting for? I'm voting for "A" party, because "A" party has promised to end the role of private healthcare within the NHS'.

'For us, popularity is already there, and we see that in poll after poll. For example, The Nuffield Trust surveyed peoples' attitudes towards the NHS; around 90 per cent totally agreed with the founding principles of the NHS [3]. Healthcare free at the point of need. Publicly funded from general taxation and publicly owned. The public is still totally on side with that. Our job between now and the next general election is to make this issue as salient as possible for the public, and to show to the politicians that they really cannot bypass this issue. If they need these votes, they have to make a strong commitment to keep private companies out of the NHS in order to win the next election.

How important is it for groups like We Own It to work together?

'This is really important. We always work with groups like yourselves. I have been involved with campaigns for almost a decade now. When I plan campaigns or create a campaign strategy I like to think 'what are my resources in my campaign?'. Some of these resources are not going to be ones *We Own It* controls but are available to other allies of ourselves. So Keep Our NHS Public, for example, has a much stronger local group network than we do. In order to have a strong impact on some campaigns you need people in strategic areas in the country making those demands at a local level. Those are resources KONP has which are really important for winning the campaign. So I make sure I bring KONP on board. KONP are one of our strongest allies in all of our NHS campaigning.

'Individually we can get quite a good number of wins but together we can do a lot more. The NHS

SOS coalition is proving that [*DFNHS supports this*]. All of the groups involved in the coalition reach at least 7 million people together but fewer individually. It's really important that we work together.

How important are doctors for your NHS campaigns?

'I think doctors are really key to this. If you compare the doctors' organisations to the nurses' organisations (thinking about the Royal Colleges, as opposed to nurse-led health campaigns), the latter are quite reticent about being explicitly against NHS privatisation. Which to some extent I understand, because of the complexities of a union that brings together people of different political attitudes. But we have found that the BMA, and groups like DFNS, don't have that apprehension at all. A lot of the resources that I use for my campaigns for making the case to politicians are actually BMA resources, which in my view are amongst the best evidence-backed resources against privatisation that there is. I am currently writing a briefing for Labour on policy arising from our action against the Health and Care Bill, and BMA resources are important for that. It's key for me that we work with doctors and groups such as DFNHS.

How hopeful do you feel about success?

'This is quite difficult to assess! I would say though that the Labour party is not where we want them to be right now on these important issues, especially as regards the NHS. But I think people exaggerate when they say the Labour party is the same thing as the Conservative party. We work closely with a lot of MPs who are already on side, but in order to win we need to find ways to work with the MPs who are not already on side. *We Own It* can't take the full credit for this, but Wes Streeting was quoted in the *New Statesman* recently [4] making a strong case against NHS outsourcing, saying that the Labour party or Rachel Reeves was promising an insourcing revolution, and that they would want to see some of that within the NHS as well. That's not the total message that we would want to see, but it's a move in the right direction. On another occasion, a Labour MP to the right of the party responded to an e mail about NHS privatisation saying that private healthcare's interest is profit but the NHS's is good health and wellbeing. That is not something I would have expected them to say in the past, and I think the movement is having more success making it clear that this is in many ways a life or death issue.

'One of the mantras we've taken on recently is that NHS privatisation kills, reflecting recent research which shows excess deaths from privatisation [5]. This is important because it puts politicians in the position of saying 'I know NHS privatisation kills but here is why I am willing to tolerate people dying'! When we've got responses from Conservatives to this, they are not trying to make that argument – essentially they are trying to deny this is happening. I think this is a good place for them to be. Because the more we saturate the public sphere with evidence that that's happening it becomes less possible for them to do so.

'So I am quite hopeful but also being very realistic that in some cases we will have to take things that are less than what we want. In other cases, the win is not going to be in the form of getting a commitment or taking some kind of action, but getting them to concede our premises, which is that privatisation hurts patients and hurts the public.

A critical year

'2023 is in many ways the most important year in the life of the NHS. We anticipate there's going to be a general election next year. This year needs to be the year that we do the work of getting the different parties to make as strong a set of commitments as they can make, or will be forced to make by our campaigning, in their manifestos. Obviously just making commitments is not enough but getting commitments is the first step. It's harder to get someone to do something when they are in government when they didn't promise you they were going to do it. We need to get them to make us that promise now, so that if they end up in government we can point out 'here is something you said'.

'We used this as part of our success in preventing the sell-off of Channel 4. So saying to politicians 'you said you would do this, now do it' doesn't just strike at the fact that this is the right thing to do, it often strikes at whether the politician is trustworthy or not, which no politician wants the public to think about them.

'It is really important for us to use this year to put pressure on politicians of all parties to commit to getting private companies out of the NHS. This is the year for that. This year, we want to get the politicians to pledge to take steps in moving our NHS back to what it used to be: a publicly owned, publicly run service that nurses and doctors are proud to work in and that the public loves. Polling after the pandemic showed that the NHS was one of the top reasons why people were proud to be British. We want to take it back there.

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- **We Own It: https://weownit.org.uk**
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Crisis, what crisis?

Going private may suit the rich but is not an option for most. John Puntis says the government is wilfully in denial on the NHS they have run-down over 13 years. It's time to pay staff a decent wage and invest.

Many working in the NHS as well as those who depend on its services see the current situation as being one of crisis.

Lack of community care prevents patients from being discharged from hospital and beds being freed both to accommodate acutely ill patients and those needing planned procedures. Ambulances are unable to move patients into rammed A&Es, and wait outside, unavailable to answer emergency calls. The government presents this as no more than "an extraordinarily difficult time" [1]. Speaking to parliament, Steve Barclay, Secretary of State for Health and Social Care, blamed this on flu, Covid, Strep A infection, staff sickness and delayed discharges.

Harm to workers and harm to the community

Widespread strikes in the health sector, including unprecedented action by the Royal College of Nursing, are a testimony to the extreme pressure on staff from both intolerable working conditions and the cost of living crisis. Real terms wages have fallen by around 20% since the Conservative government took power. It is well recognised that poor staffing is bad for patients [2], and those taking industrial action often cite this to explain their motivation. Instead of responding positively to pay demands and recognising considerable public support for health workers, government has turned to legislation [3] that will make it more difficult for staff to strike, with the threat of sacking for those who do.

Vacancy rates and a long-term absence of any workforce plan undermines the claim that this legislation is about a new-found interest in maintaining safe services. A recent survey indicates that with the current 133,000 unfilled posts things can only get even worse, with four in 10 doctors [4] and dentists saying they are likely to quit over 'intolerable' pressures. Meanwhile, the number of working age people claiming disability support has doubled post-pandemic. Record numbers of people are taking early retirement, most commonly because of ill health. Nine million people are now 'economically inactive'[5], with 27% giving long-term sickness as the reason. All of this shows that the UK cannot afford the NHS to fail.

Ambulance crisis

Ambulance Chiefs keep repeating that services are stretched beyond the limit. Patients are literally dying in the back of ambulances, while in 2021 it was estimated that up to 160,000 were coming to harm [6] because of delays. In the same year, the West Midlands Ambulance Service acknowledged that it was causing catastrophic harm to patients. Last December, response times across England were the worst on record. One medical college president [7] observed that pressure on the NHS was now so severe that it was breaking its 'basic agreement' with the public to treat the sickest in a timely way, commenting 'the true barrier to tackling this crisis is political unwillingness; the current situation is breaking the workforce and breaking our hearts'.

Criminal inaction by government is causing huge numbers of unnecessary deaths

In 2021, the Royal College of Emergency Medicine published an estimate of the number of deaths across the UK associated with crowding and long waiting times in Emergency Departments (ED) of 300-500/week [8]. The authors analysed Hospital Episode Statistics and Office of National Statistics data in England. Studies elsewhere have previously shown that delay in moving patients from the ED to a ward increased the risk of death. Conversely, risk decreased when movement of patients was speeded up. Such an estimate therefore seems entirely plausible given that the ED is simply not equipped to provide ongoing treatment and levels of nursing care needed.

The study demonstrated a steady rise in death by 30 days for patients who remained in the ED for more than 5 hours from their time of arrival. One extra death occurred for every 82 patients delayed for more than 6-8 hours. The data was published only after peer review and the methodology used in reaching the conclusions is clearly set out. Importantly, other experts agree [9] the figure is perfectly reasonable, and may indeed be an underestimate. A repeat analysis using more recent data came up with an estimated 530 deaths a week.

While of huge potential significance, this type of study cannot absolutely prove delayed admission causes deaths, meaning the conclusions are open to challenge. Representatives of NHS England, however, cannot get away with simply stating: "It does not recognise those figures". A more serious response is required and they should show where they think the paper is wrong and share their analysis for consideration and response. This process is essential if policy decisions are to become more science based and therefore effective in terms of protecting patients.

More or less everyone but the government thinks the NHS is in crisis.

Jeremy Hunt, when Secretary of State for Health, liked to present himself as a champion of patient safety. Against this, journalists respond [10] that on his watch we find missed targets, lengthening waits, crumbling hospitals, false solutions, funding boosts that vanished under scrutiny, and blame apportioned to everyone but himself. In a recent report [11], as chair of the Commons Select Committee on Health, he concluded that: "We now face the greatest workforce crisis in history in the NHS and in social care, with still no idea of the number of additional doctors, nurses and other professionals we actually need", adding that this was putting patients at risk of serious harm.

The 2022 report also stated: "It is unacceptable that some NHS nurses are struggling to feed their families, pay their rent and travel to work", suggesting they be given a pay rise to match inflation. For Hunt, now chancellor, this has been conveniently forgotten, with the Treasury being cited as the main block on progress in pay talks. Meanwhile, the House of Lords Public Services Committee [12] opined that: "The state of emergency healthcare is a national emergency. The substantial delays that patients face when trying to access emergency health services create . . . an unprecedented clinical risk".

Downward spiral but no credible plan

Responding to current performance statistics, the Health Foundation [13] commented: "these

figures show a gridlocked health and care system struggling to meet the needs of patients . . . in October 2022, hospital waiting lists hit a record high of 7.2 million, with nearly 411,000 waiting over a year. More than 1 in 10 people with a serious condition such as a stroke or chest pain waited over 105 minutes for an ambulance in November, while nearly 38,000 people spent more than 12 hours on trolleys in A&E". In addition, 39% of urgent cancer referrals [14] waited longer than the target 2 months to receive their first treatment.

The Department of Health and Social Care commissioned a report from the King's Fund [15] to help it understand how this situation had arisen. The thinktank helpfully concluded that a "decade of neglect" by Conservative administrations has weakened the NHS to the point that it cannot tackle the huge backlog of care. Specifically, years of denying funding and failing to address its growing workforce crisis have left it with too few staff, too little equipment and too many outdated buildings.

It is no surprise that a Tory party in power for 13 years is reluctant to admit the NHS is in crisis as this would mean taking responsibility for the mess. The pining for a more privately funded system is neither fair nor makes economic sense [16]. Recent promises of improvement [17] without the necessary staff represent only a sticking plaster. The government should reflect on the fact that the vast majority of the public still support the core principles [18] of a public service. The NHS itself has not failed, but has been failed by politicians, and politicians deserve to pay a political price.

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- **John Puntis is co-chair of Keep Our NHS Public. This article originally appeared in the *Chartist* magazine (https://bit.ly/3TnqGuO). Reproduced with permission.**

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De-commissioning the family doctor

Early in February there were several news reports of the possible/probable replacement of a well-liked, highly reputed Family Doctor practice (the Whitnell Health Centre) by an entrepreneurial commercial health conglomerate (SSP Health).

All the reports concur in the following: this established practice had excellent long-term stability, high levels of patient and staff satisfaction, and very satisfactory measurable outcome indices.

Nevertheless, the Integrated Care Board (the commissioning body that decides and awards NHS GP contracts) has initially favoured SSP via a points-based decision: SSP scored higher in plans for IT and HR, despite its far less favourable record – over many sites – surveying patients' experience and satisfaction. The decision has now been challenged.

Some media reports talk optimistically of a 'watershed moment' where we might retrieve and freshly assure GP services that are smaller-scale and staffed by familiar people – where we can again get to know, and matter to, one another. This optimism harks back. In previous decades the traditional moniker of 'family doctor' was very apt in a number of ways: those erstwhile practices did, indeed, know and understand not just individuals-within-families, but their other embedding connections and neighbourhoods. Such family doctors' responses were, therefore, more readily sensitive, holistic, bespoke and healing because of those relationships.

Those previous, smaller practices themselves were like well-functioning families, too. Their staffing scale and stability encouraged (mostly) relationships of personal understanding, trust, natural synergy and care. Family doctors could be, and were, communities-within-communities.

For all its unevenness the era of the family doctor was, generally, far more trusted, popular and efficiently responsive than our current regimes of competitively commissioned Primary Care Service Providers selected and refereed by Integrated Care Boards (sic) – the often clumsy, if not nepotistic, behemoths we have now.

SSP Health and its kindred commercialised enterprises burgeon and play well on this slanted pitch: their size, business-seasoned savvy and mindsets mean sharp negotiating skills and glossy promises.

But what such corporatised and commercial health providers actually 'deliver' to individuals is so often alienating, frustrating and worse. Such commissioned services are now almost all devoid of the sterling community-within-community qualities that nourished and sustained previous generations of GPs, their staff, and patients. Instead we are 'serviced' by increasingly large and remote conglomerates.

These are staffed by unfamiliar, often anonymised teams that are usually rotaed by managerial decree and must adjust to gig-economy working conditions. Engaging with such cybernated and gigantised health providers has become more and more like attempting to get personal attention and understanding from any utility provider – the electricity or digital network service, for example. Even if you are fortunate enough to encounter a kindly and (relatively) unstressed practitioner it is unlikely to be anyone with whom you will ever develop a trusting familiarity and understanding – both you and they will probably be limited to a Kwikfit-fitter experience. Personal continuity of care – a good index of a stable, vocationally-

spirited GP workforce – becomes here very rare indeed.

Does this matter? And if so, why?

Well, it matters deeply and extensively. Not only to the quality of experience to the givers and receivers of our healthcare, but also to the very measurable costs and outcomes. Repeated research has shown how greater personal continuity of care is related not only to greater consultation satisfaction shared between practitioners and patients but also to the following: better control of chronic diseases and risk factors; less use of emergency services, A&E and acute hospital admissions; fewer specialist referrals and investigations; better patient compliance to fewer prescribed medications; and – remarkably – significantly longer longevity.

So the losses and damage that ensue from our jettisoning personal continuity of care are considerable. (Metastudies and original research clearly demonstrating all this can be found in many years of publications from a team at the University of Exeter, headed by Denis Pereira Gray.)

Apart from the subtle and deep losses here to people, the cumulative wastage to our national economy is massive. The specious reforming belief has, for three decades, been that by scaling-up, marketising and corporatising our general practice it would become better value and safer. The folly of such beliefs is now very evident in our unravelling, depopulated and demoralised services. Everyone is unhappy: GPs cannot practise as they would best judge or choose, patients cannot get the personal care they need (or even an appointment), and managers know they cannot manage to manage all this…

The suggestions that this challenge to the Integrated Care Board heralds a 'watershed moment' may, sadly, be more heartening than realistic. For the past three decades of reforming tides have swept away almost all that once existed of our communities-within-communities – our familiar healthcarers working in smaller, very local premises with gentler and more sustainable work satisfactions.

The systematic destruction of such 'therapeutic communities' is not now easily reversed. As town planners found several decades ago, newly tower-blocked residents could never restore the neighbourly kinship that had sustained and nourished them previously in their then-demolished old streets of terraced houses. Those relationships depended on a smallness of scale and accessibility that was horizontal; scale these up and stack them vertically, and such relationships all but disappear. They cannot be simply designed back.

Such are human eco-systems, and we have largely lost our perception of the NHS being an eco-system needing our sensitive and imaginative stewardship; instead we are treating it as an engineering or business project – to be specified, competed for, tendered, chivvied, bribed or threatened into its desired form…

'You can't turn the clock back' – an oft-used retort. A truism, yet often unnecessarily and unwisely limiting because it may discourage us from looking back and seeing what we may now learn. So here, with our healthcare, is the discouraged and discounted option: we can survey the past and ask: what used to work better? Why and how was that? What from this could we now restore and reconfigure? And how?

Liberating watershed or darker denouement? That depends on whether we embrace or avoid such questions.

- **Many articles exploring similar themes are available on David Zigmond's Home Page (https://bit.ly/3JTMOdp)**

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Book Review

Firms as Political Entities: Saving Democracy through Economic Bicameralism
(£21.99, Cambridge University Press, paperback)
Isabelle Ferreras. 2017, 213 pp.

Isabelle Ferreras sets out in this scholarly yet eminently accessible magnus opus the solid philosophical moral and legal base for the transformative change, urgent beyond words, to save us from the constellation of apocalyptic catastrophes threatening the future of life on our planet.

The thesis is succinctly encapsulated in the title and subtitle.

How our world order has arrived at the tragic position of enslavement of the vast majority of the world's workforce through the absence of democracy in that thing we do most in our waking hours, i.e. work, is revealed.

Throughout we are brought increasingly to realise and understand the crucial distinction Ferreras recognises between the 'corporation' and the much larger and more profound 'firm'; 'corporation' and 'firm' have become so conflated that the firm has become invisible; Ferreras lifts the veil and shows us the firm and the political entity it must be.

'Expressive Rationality' is the term coined by Ferreras to identify the fundamental distinguishing character of the firm; it is the inclusive term for releasing the ocean of goodness and creativity currently suppressed more or less completely in the global working population on account of the concentration on the corporation and its morally inferior 'Instrumental Rationality' concerned as it (primarily) is with profit.

Imbued throughout is a sense of optimism and hope as we are shown the feasible route to transition from the prevailing 'Unicameral, Capital-Managed Institution' with its enslaved workforce to the 'Government Structure of the Bicameral Firm Composition of Chambers' where 'Capital' and 'Labour' have equal voice.

How might all this translate in the context of the NHS?

This will depend on what now is the NHS? Is it what it was until recently a National Service, or is it now (in England) 42 so-called Integrated Care Systems? Given that funding comes from central government it is rational to recognise the state as the 'Chamber of Capital' (by so doing, this could reunite the four nations in a democratised, functional, humanised NHS).

The 'Chamber of Labour' would then be the entire NHS workforce. But a vital question would

then be in which of the two 'Chambers' to place the beneficiaries (public, patients, 'customers' or 'clients')? This gives us two possibilities, in this model of the NHS:

1. The Chamber of Labour (or an advisory council to that chamber).
2. The Chamber of Capital (ie the State)

The important point is that all major decisions including regarding structure and delivery of the service will require unanimity between the two chambers; the 'Chamber of Labour' would have the power of veto if they are were not happy with the direction of travel.

Whilst the first option might at first seem more logical, the second might give greater strength to the reforming, rejuvenating power this democratising movement would bring; it would further mitigate the influence of the state providing an obvious and natural alliance between the two chambers.

Musicians making music in an ensemble was an analogy a young A&E nurse on the Barnsley picket line recently recognised as describing how she would like to see and experience her work. Could this way of perceiving and defining work, and how it interfaces with democracy, generate such an orchestral synthesis for the NHS itself?

Ferreras poses and convincingly answers 25 penetrating challenges to her analysis in the final section: 'A Reader's Guide for Reflection and Debate' (I wondered if they were her challenges to herself or are the challenges she has faced from others).

'Firms as Political Entities' and the issues around 'Work' and 'Democracy' have direct relevance for health and hence for DFNHS at multiple levels, most important to identify two broad and overlapping categories:

1. The biggest influence on health (or 'ill-health') is societal; the nature of 'work' is surely one of the most influential societal factors and therefore DFNHS's concern.
2. One particular category of work is that involved in the delivery of health and care services including our NHS and is therefore our immediate concern.

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***Mike is leading a sub-committee reporting back to EC on how the principles explored by Professor Ferreras and her colleagues on the democratisation of the workplace might be defined and expressed for the NHS.**

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Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

Covid was never the only threat...

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