NHSCA

EDITORIAL June 2010

TOMORROW'S DOCTORS – TOMORROW'S NHSCA?

The NHSCA website is headed by the quote from Nye Bevan that "the NHS will last as long as there are folk with the faith to fight for it". But are there still such "folk" coming up through the ranks of the current NHS? Or will the corollary of Bevan's quote be that the NHS will cease to exist because there is no longer the commitment to fight for it? Not, of course, that Bevan would have seen doctors, let alone consultants, as at the forefront of the fight for the NHS in the 1940s, but the support of doctors rapidly became critical in NHS survival. It seems to me that if doctors lose faith in the NHS now, the general public and the wider healthcare community will find it much more difficult to maintain campaigns such as the NHS Support Federation and KONP. This is why the BMA campaign is so welcome – and why maintaining the NHSCA is so important.

But do the aims of the NHSCA resonate with young or aspiring consultants? I think this is questionable. The medical profession is changing in many ways, as discussed below and in the article by Ali Bakran later in this Newsletter, and many of these changes are inimical to the aims of the NHSCA.

It should be of concern that the NHSCA already has more older than younger consultants and that of the active core members of the Association a considerable proportion are retired. It could, of course, be argued that retirement provides time for campaigning which a full time clinician does not have, but most of these members were politically active throughout their clinical careers and there seem now to be genuinely fewer such activists in the profession.

To appreciate why this might be, I believe we need to look at the experience of the most junior groups of the profession and the extent to which this has changed over the years since most NHSCA members were students and junior doctors. Having spent the last 10 years in a medical school working mainly with pre-clinical students I can testify that these changes have been profound.

Attitudes to the NHS have changed. We are told so often of its failings and so rarely of its achievements that many truly believe that there must be a better way to deliver health care. Many current members of the NHSCA would have known from their parents the reality of the "fear of illness and disability" from which Nye Bevan famously promised deliverance. The current generation have known only free health care, take it for granted and assume it will continue to be provided under a commercial system.

Politics have changed. My generation were political. We campaigned and marched and joined political groups of all persuasions. It was considered odd if you were not involved in campaigning for something. A few years ago I asked an applicant for a junior job what made him angry. He looked blank – he didn't get angry. Well what did he feel sufficiently strongly about, for example, that he would join a protest march. He remained completely blank; he really didn't understand the concept. I thought it sad – but I suppose for the modern medical manager this is the ideal worker, compliant and "corporate". Leave politics to professional politicians.

The students have changed. When I entered medical school in 1968 children of doctors (and outstanding rugby players) were disproportionately represented, but most of my colleagues were grammar-school educated. There was a 15% quota for women. There were, in my medical school at least, virtually no overseas students. Today women are in the majority, privately educated students predominate, and there is active recruitment of overseas students and the substantial fees they bring with them. I was one of an intake of 30. St George's, where I teach, is now a "small" medical school with an annual intake of 240. The concept of the student as an apprentice is no longer credible and medical students are just another faculty, not an elite professional group.

There have been profound changes in students' educational experience prior to medical school. Much of my sixth form learning was done independently. We read books and were expected to make our own notes and reach our own understanding. Going to university may have involved a huge social change but it was not a huge change academically. It is now. School league tables have completely distorted the educational process in schools. Teacher's jobs and pay can be dependent on their students' exam results so students are simply taught to pass the exams. They arrive at university assuming that there too the goal is to pass the exams (seeing this as somehow completely unrelated to being able to look after a patient) and that they will simply be "taught" anything they need to know to achieve such a pass.

Many have no concept of learning as "work", ie requiring effort, or as their responsibility. This passivity extends into their clinical attachments which are, in any case, considerably more restricted in length and scope than ours were.

Although most students have early contact with patients this is very carefully managed so that patients seen are "typical" and have clearly defined conditions. The same is true of the clinical scenarios which form the basis of currently fashionable "problem-based learning" curricula. These "virtual patients" have none of the messiness or uncertainty of real patients and reinforce the idea that there is a single right answer to any problem. New graduates then see nothing unreasonable about being

required to follow protocols and algorithms rather than developing clinical judgement.

Attitudes are also, as they have always been, strongly influenced by the example of their consultants and teachers. They see their consultants target-driven, time-managed, unable to teach because of the clinical requirements of their job-plans, unable to act in the best interests of a patient if this is not in the financial interests of the management. Their role model is a bureaucrat not a professional.

Once qualified they are deterred from taking responsibility and their post-graduate training is a heavily bureaucratic tick-box exercise which will worsen with the introduction of revalidation. "Run through" training, the European Working Time Directive and the proliferation of non-medical staff doing previously medical jobs has drastically reduced their post-graduate experience, resulting in the appointment of consultants who are not truly ready for the independent practice the role used to involve.

But the most fundamental change of the last 30 years is financial. The cost of medical training is now such as to deter all but the rich or the most strongly motivated and to ensure that issues of salary feature more strongly in career aspirations than issues of service to society. My medical training was paid for by the taxpayer. I owed a job I loved and could not possibly have paid to train for myself to the NHS. In turn I owed the NHS and its patients the best service I could offer.

Today's graduate has massive debts (see article below) and not unreasonably feels that they owe nobody anything. Why should they not sell their services to the highest bidder? Throughout their lives they have been told that "markets" are the only way to run the world. What is wrong with buying and selling health-care just as they have had to buy and sell education?

"Top up fees mean that universities are increasingly under pressure to confer degrees upon students who perceive the degree as a commodity they've purchased. Failure doesn't enter into anyone's calculations."

Sarah Churchwell. "The Independent" July 11th 2007

But let us end on a more hopeful note. Graduate students in particular often bring to medicine a breadth of experience, social insight and an old-fashioned sense of vocation. There are still medical students who are politically aware, as exemplified by the item below from Sindy Lee. There are still students who feel strongly about social problems and are prepared to campaign against inequality and social exclusion. MedSIN (Medical Students International Network) is active in many medical schools. Supported by MedAct, this group campaigns on global health issues and the reduction of health inequalities. The BMA still has an active student committee strongly supporting the "Look after our NHS" campaign. Students continue to volunteer for local and international community projects. So the market has not yet triumphed and there is still hope for the future – of the NHS and the NHSCA.

JANET PORTER

Guest editor

LETTERS TO THE EDITOR

Dear Sir,

I must have had a busy couple of months as it has taken me to mid May to get to the back page of my March issue of NHSCA.

I was somewhat amazed by the tone and content of the article on Assisted Dying.

A few questions occurred to me.

Why have only two out of fifty states in the USA passed any laws on assisted dying? Why have only the smallest countries in Europe done the same? Only Andorra, Liechtenstein and the Vatican undersize the countries quoted but I can't see much change coming out of the last mentioned.

Secondly I wonder if a novelist diagnosed with Alzheimer's, however eminent, is the right person to opinion form on the topic?

Thirdly has Polly T lost her marbles? "Every day in hospitals, nursing homes and at home the state …orders the torture of the terminally ill."

Come off it Polly surely we hard working doctors and nurses can take an occasional day off from our nefarious practices.

I look forward to further enlightenment in subsequent editions

Peter Davies

Consultant Physician, Liverpool Heart and Chest Hospital.

Dear Editor

Professor Davies raises three objections to my short article on assisted dying. First, he criticises what is in effect the small size of the states or countries which so far have permissive legislation.

I fail to see that relatively small population size invalidates some years of relevant experience.

Second, Professor Davies challenges the status of Sir Terry Pratchett's current views on assisted dying since Pratchett - as he himself pointed out - has early onset Alzheimer's. As a letter to bma news (8 May} put it "there is only one expert on Terry Pratchett's life and that is Terry Pratchett ..."

Third, Professor Davies also dismisses Polly Toynbee's challenging metaphor about the current legislation as though she is foolish to suggest that the present law causes a significant volume of avoidable suffering. Relevant here is the fact that social surveys show large majorities in favour of assisted dying. For instance, a British Social Attitudes survey (January 2010) shows strong support for assisted dying for people who are suffering, with 71% of religious people and 92% of non-religious people agreeing that "a doctor should be allowed to end the life of a patient with a painful, incurable disease."

I can't emphasise too strongly that those of us advocating a change in the law seek permissive legislation. Public and medical views differ. The present law satisfies only those who reject assisted dying.

Peter Draper

ELECTIONS 2010

There has been a flurry of these since our last edition.

In the Westminster event, the gods must have taken fiendish delight in fashioning a result which initially left every Party disappointed.

Although in no way a Party, NHSCA had its own internal disappointment in seeing our member **Richard Taylor** defeated in the Wyre Forest constituency which he had won as an Independent in 2001, causing one of the most dramatic upsets of that election. His platform then was essentially retaining vital services at his local DGH which was being raided to enable the building of a PFI hospital elsewhere. He can feel very satisfied with his success in getting this issue into the public arena, holding the seat in 2005 and his work as a member of the Health Committee.

Now we and similar bodies working to maintain and enhance the concept of the NHS as a public service have to plan our strategy in the new political situation which has emerged. Our Executive Committee will be meeting on 3rd June to start this process and KONP has its AGM very conveniently placed on 12th June. We would be delighted to hear from any member who has personal experience of dealing with any of the new Government's Health team.

In other elections there have been noted successes for NHSCA members:-

We are very pleased to be able to congratulate **Richard Thompson** on becoming the next President of the Royal College of Physicians. He takes up office in July.

Similarly the re-election of our Co-Chair, **Jacky Davis**, to the BMA Council is excellent news ensuring that she will be able to continue, with like-minded colleagues, to press for that organization to maintain its current anti-market stance.

"CURE THE NHS" NATIONAL NETWORK LAUNCH

April 29th 2010

Distressed by the revelations of the Mid-Staffs Report, encouraged by the governments full acceptance of the recommendations, curious to learn why a hospital was requesting to lose it's FT status and concerned to learn how I might help to halt the deterioration in care at my local hospitals, it seemed a workshop worth attending.

And so it turned out…..a vigorous, informative day in the company of committed individuals with much to say and with no shortage of passion in saying it.

The front cover of a comprehensive handout defined the day as "A workshop for everyone campaigning to get to the truth from the NHS and to make it the service we all want and need". Fighting talk indeed and talk much lacking from our Politicians recently, me thinks. The fact that we didn't spend much time in workshop activity hardly mattered.

Julie Bailey, co-founder of "cure the NHS", described how far this campaigning relatives support group has come over the two years since they were formed and her full story in the handout graphically detailed the battles she had over her mother's care with problems over medical diagnosis investigation and resuscitation, nursing care and competence, senior management indifference and denial and much else, through to local MP's and official Government bodies until she was finally given an audience by the Health Care Commission. There was valuable advice from her on the lessons she had learned e.g. in how to cultivate the Media and the need to avoid being sucked into the management system and thereby be rendered voiceless.

Peter Walsh C.E Action against Medical Accidents (Tel.020866889555 www.avma.org.uk) described the work of this independent charity, which promotes better patient safety and provides information, advice and support to people affected by a medical accident, through a national helpline dealing with 4,000 enquiries a year "probably the tip of the iceberg",and referral to accredited specialist solicitors in Clinical negligence and Medical Law.

He defined his campaigning priorities as :

- "Better regulation"—National Patient Safety Alerts (NSA's) are sent to all Trusts for implementation but are not always implemented
- Care of the Elderly
- Pursuit of a Duty of Candour—there is currently no statutory requirement to inform families and patients of events. (this legal duty was contained in the Liberal party manifesto).

Monica Dennis, Founder Member "A Dignified Revolution" (tel.07811159800,)

e-mail:info@dignifiedrevolution.org.uk, www.dignifiedrevolution.org.uk), gave a moving account of the origins of the group, it's current focus, and it's challenge to the NHS under the title ***"Who took the nursing out of nurses? Who's going to put it back."***

With a nursing background, having worked on projects with Age Concern in Wales, currently working as an independent Consultant, Monica and the Group are focussed on:

- ensuring that the dignity and respect of older people is a key priority for all health and social care professionals
- encouraging the general public to challenge rather than tolerate unacceptable attitudes and inappropriate care

In answering her introductory title, she traced the changes brought about in nurse education with the demise of Schools of Nursing, the development of academic establishments, the emphasis on training at the cost of patient care, attitude and behavioural issues not only leading to an "us" and "them" culture but with assumptions emerging that basic nursing care is not part of a qualified nurse's role but that of a health care assistant.

Strong words, met with nods of agreement from an audience containing many older generation nurses.

She offered that solutions lay in Directors of Nursing taking on a traditional ward-centred role, with insistence on sufficient staff levels. She questioned whether a "3 A-levels" approach to nurse selection was appropriate without interview.

She concluded by calling upon hospitals to meet the "Gandhi Challenge":

"The patient is the most important person in a hospital, not an interruption to one's own work; he/she is the purpose of it, not an outsider but part of it, doing **you** a favour by giving you an opportunity to care….."

Reading her entry in the handout afterwards I noted in her challenges to the NHS that "Patient Support services should be provided in all hospitals and that service users should be involved in hospital staff induction programmes, so that staff are educated in what the public expects."

A short lunch break allowed group members assigned for the afternoon workshop on a geographical basis to meet and share concerns before **Prof. Brian Jarman's** comprehensive talk ***"A plain person's guide to mortality statistics."*** He explained the background to HSMR's as a reasonably reliable measure of hospital mortality adjusted to take account of variables that are not directly related to the quality of treatment and care received in a particular hospital, such that comparisons can be made between hospitals. In response to questions, he implied that if politics were taken out of the equation and inspections rather than the current self measurement stats were used, correlations would be higher. It would be possible for Trusts to have more data available for scrutiny, given the will, a comment

which fitted in well with an overall message from the three excellent speakers that more transparency and less defensiveness in communication with users would prevent many problems arising.

So what were the important messages to take away from this stimulating workshop?

Too many for me to record. However our Executive Committee should consider whether the NHSCA should offer formal support to the organisation.

For those of you who may be contemplating forming a group locally you might wish to consider the following:

- Have a **clear aim** and research what is available and working well before rushing in to create something new, especially if it carries a challenge.
- What is your Local Involvement Network (LINk) doing and are they worth joining?

You may not need to create such a structured high profile group as the Mid-Staffs "Cure the NHS Group" with its clear goal to turn around the NHS and make those who provide services accountable to those who receive them. They started out as a Relatives group with a determination to be given answers and substantial improvements in the quality of clinical care. Now with two enquiries (and demands still for a public enquiry which Andrew Lansley said they should have when in opposition) and national media coverage, they are a force to be reckoned with.

You may feel your Trust/FT requires more oversight and gentle persistent challenges particularly in its clinical activities, including how it deals with the concerns it receives from the public and that it should be reminded that it is required to be more transparent in opening up Management meetings to the public, with provision of Agendas even if it becomes a FT.

To answer a question I asked in an earlier Newsletter; **No**, I don't want to become a Governor as my Trust awaits Foundation Trust status but I would like to see a more open means of communication with my Trust than currently exists, preferably working with Management to solve long-standing clinical service problems. If a fairy godmother nurse of the "Old School" were to appear to offer help with Staff induction programmes then that would be a REAL bonus.

GEOFFREY MITCHELL
Psychiatry
Beverley

For more info contact: curethenhs@hotmail.co.uk
or www.curethenhs.co.uk

WIDENING PARTICIPATION AT ST GEORGE'S, UNIVERSITY OF LONDON

The then prime minister Gordon Brown visited St George's in January 2010 to launch the government's new social mobility measures. The plans include widening access to higher education, an area in which St George's has been a national leader over the last few years.

The multi-award winning St George's Widening Participation Unit works with students of all ages and backgrounds, from primary school to mature learners, supporting their educational development and aiding their transition through their studies and on into Higher Education. The team reaches over 3,000 state school pupils each year to support their educational development, raise their aspirations, challenge inaccurate stereotypes and inform them of their career options.

Amongst these initiatives is the adjusted criteria (AC) scheme, pioneered by St George's and launched in 2003. This access scheme helps to level the playing field by considering applications to study medicine in relation to the peer group with which applicants studied, rather than in relation to the national average. Under the scheme, the standard AAA entry requirement can be dropped to two Bs and a C if a student's results are 60 per cent better than the school's average. Evidence shows that those students entering with lower grades perform just as well on the course from their first year exams onwards.

Other initiatives include school visits, residential summer schools and the tasteofmedicine.com web site to raise awareness about opportunities in medicine and healthcare.

Admission interviews have been replaced by a new scenario-based multi mini interview (MMI) process designed to assess the skills and characteristics that make a good doctor beyond academic achievements.

As a result of these initiatives the proportion of students joining St George's from state schools has increased from 53 per cent nine years ago to over 80 per cent today.

KENTON LEWIS
Head of Widening Participation & Student Recruitment

AEQUITAS "EQUALITY THROUGH EDUCATION"

A new Coalition Government has barely entered Parliament and all those who work in the NHS must be apprehensive about prospective cuts and austerity measures which will inevitably be imposed in view of the financial crisis and change in political complexion. However, there are also raised expectations in other areas if the Conservative manifesto promises are truly implemented, which will have an indirect but positive impact on the NHS, albeit some time in the future. The manifesto stated that the Conservative Government intended to "raise standards for all and close the attainment gap between the richest and poorest… improve social mobility through the development of academy schools in deprived areas with the ability to transform life chances….education's real power lies in its ability to transform life chances and improve social mobility."[1] This was an aspiration which, unfortunately, the previous Government failed to achieve despite considerable effort and the spending of substantial funds. Are these merely warm words with no substance or will action follow?

Worryingly, there are some concerns. The Sutton Trust's recent analysis of the new intake of MPs into Parliament throws up an astonishingly narrow range of educational experience of these MPs. Oxbridge provides 38% of Conservative MPs, 20% of Labour MPs and 28% of Liberal Democrat MPs, with 35% of MPs attending independent schools which only educate 7% of children. Only 43% of MPs were educated in comprehensive schools whilst 22% were educated in state grammar schools. Indeed just 13 schools, 12 of which are private, produced 10% of all MPs![2] It is an unexpected and curious state of affairs when even the Daily Mail has an article entitled "Nick, Dave and the death of social mobility" and which concludes with the words "the dream of a genuinely fluid, open society with opportunities for all regardless of background" seems more remote than ever." The article goes on to point out that the days of state school educated Prime Ministers of the past, Harold Wilson, Ted Heath and Margaret Thatcher, may have passed.[3] Are these MPs, whose experience of life in general is narrow and contact with the poorer sections of society in particular limited, capable of responding to the needs, hopes and desires of all the people of Britain? In particular, will the "gilded" lives of David Cameron, Nick Clegg and George Osborne allow them to protect the poorest members of society from the financial pain that inescapably must follow? What is obvious is that the ruling elite is not reflective of the wider society and has never experienced true hardship to give it insight into how economic and social policy affects the lower echelons of society. It is also apparent that social mobility through the educational system remains an elusive aspiration.

Recent news is not all bad, however. The Sutton Trust again reports that there is some evidence of an improvement in educational ability in that the advantages of having degree educated parents in terms of performing well in tests at the age of 11 and 16 has diminished and a closing of the gap of obtaining at least five GCSE's with grades A* to C has fallen from odds of 6.5 times in 1974 down to 4 times for children of degree educated parents compared to children of those parents who did not go to university. Nevertheless a significant attainment gap remains between children of degree educated and uneducated parents.[4] Longitudinal analysis of children reveal that educational advantages of children of higher educated parents compared to lower educated parents widens throughout the school years especially between the ages of 11 and 14 years and is accounted for by the former attending higher performing secondary schools. The school impact is likely to be due to better resources, better teaching, better advice and positive peer group effects in these schools.

International comparisons in the same report suggest educational mobility is less in England compared to other developed countries, even than in the USA with its particularly high gap between rich and poor. In England 56% of children of educated parents are in the top 25% tests at 14 years of age compared to 23% in Australia, 37% in Germany and 43% in the USA, implying that children of poorer less educated parents do better in these countries. The differences in maths attainment shows a gap of 4.7 times between those children from socio- economically favourable and unfavourable backgrounds, which also compares badly with international comparisons. Therefore, the highly segregated school intakes in England compared to other countries do not favour educational mobility and, consequently, it is also likely that social mobility will be restricted compared to other countries. The UK does run the risk of deteriorating further in international comparison league tables. Can the UK afford this when it is competing in a global economy? The failure to respond to these challenges will condemn many children's life chances and, most importantly, waste the talent that is desperately needed to compete in world economy.

Even the situation in comprehensive schools is perversely distorted against disadvantaged school children. Alan Smithers and Pamela Robinson have

recently shown that in the most socially selective comprehensive schools, 8.6% of children were from poor backgrounds despite the fact that the schools were in localities where the proportion of such children was 20%.[5] Apparently these schools are even more socially selective than grammar schools! 164 socially selective comprehensive schools had a 9.2% intake from income deprived families compared to 13.5% in 164 grammar schools. Therefore, the current admission policies of these schools, which are supposed to give all children a fair chance of a less socially divided education, needs addressing to enable a fairer balanced intake.

What is apparent is that the educational system in the UK entrenches disadvantage and needs to change. This is easier said than done. Many studies have shown that disadvantage starts early in life and hence the Labour Government's attempt at giving children the best possible start in life through the "Sure Start children's centres" initiative.[6] In England these centres were to give children from deprived families a "hand up" and get their mothers into the workforce. The success of this initiative remains uncertain but it is at least an attempt to overcome ingrained disadvantage which starts early in life. The Conservative Government has committed itself to continue Sure Start although there are likely to be changes in its implementation. However, this initial support for these potentially blighted children is valueless unless it is sustained through the educational system later on.

Whilst there has been some progress in breaking down class barriers in the UK, nevertheless, they remain as a source of division within this nation. We as doctors hopefully care for our patients without consideration of class. Nevertheless, how many of us are aware of and understand the relationship between poverty, poor education, ill health and earlier death associated with income and social class, apart from public health physicians and those with a specific interest? This has been a major feature of Britain and every other nation since records began. Research performed by Sir Michael Marmot[7], Richard Wilkinson[8] and many others, confirms the relationship between income and outcome. Indeed the recent book by Richard Wilkinson and Kate Pickett entitled "The Spirit Level" details this relationship vividly.[9] Not only must there be a reduction in the vast difference between the very wealthy and the very poorest in this country if we are to address these public health issues but also advance must be made through the educational system to redress some of these fundamental problems. The Sutton Trust, whose principle objective is to improve educational opportunities for young people from non-privileged backgrounds and increase social mobility, continues to fund relevant research into the deficiencies in our educational system. These deficiencies can only be really tackled effectively by national government through nationally driven policies to eradicate poverty and educational disadvantage.

Education is important since it enables many to lift themselves out of poverty, is the best driver for social mobility and helps realise the full potential of individuals irrespective of their background. Helping people out of poverty will enable them to live a healthier life style, hopefully with less dependence on the NHS and lead to a fitter aging population. Hence health, poverty and education are inextricably interconnected. With the appointment of Sir Michael Marmot as the next President of the BMA, the health inequalities agenda will have a powerful public advocate in place to improve the understanding of doctors that health inequality is not primarily related to healthcare, although the NHS is important in managing ill health, but to our lifestyle and opportunities available to us, where we live, how we are schooled and for how long, whether we are in work, what our job is, and how much we earn.

How does this relate to medicine and the medical profession? Does the medical profession reflect the social structure of our society and does educational privilege matter as it does for MPs? The answers, of course, are no and yes. Data from UCAS reveals that university education in general is skewed heavily in favour of social classes 1 and 2 with social classes 4 and 5 being left far behind. This difference is even more transparent when entry into the medical school is examined. The BMA has highlighted this in its recent report "Equality and Diversity in UK Medical Schools."[10] This report reveals that only 1 in 7 successful applicants in medical school comes from the lowest socio-economic groups. Socio-economic groups 1-3 make up over 81% of entries into medical school and, therefore, social classes 4 –7 are marginalised. Does this matter? Should, as the BMA suggests, the medical profession reflect the wider society? Certainly there have been radical changes in terms of gender and ethnicity in the composition of medical schools intake as the report indicates. More women than men now enter medical schools and minority ethnic groups, mainly of an Asian background, form a larger than expected proportion of medical school entrants. However, these opportunities are denied to those of the lowest socio-economic status.

The last government had invested huge amounts of money in its "Widening Participation" initiative, possibly over £400m invested through the "AimHigher" and other programmes, trying to implement its target of 50% of young people between the ages of 18 and 30 years proceeding to higher education.[11] In addition, there was a firm commitment to narrow the gap in educational

achievements between children from low incomes and disadvantaged backgrounds and their peers. Furthermore, Alan Milburn headed a report on "Fair Access to the Professions" which suggested that professionals in medicine, law and even journalism are increasingly likely to be from more affluent backgrounds. For example, 75% of judges and 45% of senior civil servants were privately educated as were most solicitors, members of the House of Lords and finance directors. The report recommended that university students should come from a wider range of social backgrounds. This is a rather easy recommendation to make but not so easy to implement.[12]

The BMA report highlights the fact that social classes 1 and 2 are over represented in medical school admissions in that twice as many are accepted into medical school from these classes compared to all other university acceptances from these social groups, that just 15% of students came from the lower four socio-economic groups compared to 20% of students accepted for other degrees. Entry into medical school is certainly very competitive with the high level "A" level requirements of 2 As and 1 B in most universities However young people from lower socio economic groups achieve fewer "A" levels and usually achieve lower grades. Trisha Greenhalgh has revealed that the perception of school children in social class 4 and 5 underestimate their chances of successful application to medical school and conclude that self esteem, personal identity and aspects of working class culture run counter to traditional academic values and aspirations. In addition, there were also issues of financial constraint.[13] The BMA has repeatedly highlighted the issue of student debt at medical school in several publications. The prospect of debt is a major undesirable factor on decision making when applying to higher education institutions by prospective students as another Sutton Trust survey revealed. The BMA has pointed out that the funding system for medical students is over complex and that students coming from lower socio economic groups find this a disincentive. The BMA survey in 2008/2009 revealed the average debt of a medical student was £22, 821 but ranged up to £65,000, and which may take over 20 years to repay![14] Whilst there is a current tuition fee cap of £3,000 per annum, there is strong pressure to remove this barrier and to possibly more than double future tuition charges to £7000, as suggested by Wendy Piatt, Director General of the Russell Group of Universities.[15] This would create a yet greater barrier for students from lower socio-economic groups even though much of this cost may be mitigated by national grant and bursaries from universities.

The Medical Schools Council responded to the "Fair Access to the Professions" panel's request by stating that one third of medical schools have specific admission policies for health professionals wishing to study medicine and 16 out of 31 medical schools run foundation year or have an agreement with a programme at another institution which runs foundation year to enable entry to medical school.[16] The foundation year, or a sixth year, allows the educationally disadvantaged students to improve their knowledge and understanding of science relevant to the practice of medicine. Attempts have been made by Kings College and St Georges Medical School in particularly to widen participation by disadvantaged students but by different mechanisms. Kings College accepts students from disadvantaged backgrounds with three C's at "A" level to an extended medical degree programme.[17] In addition, students have to pass a mental agility test and an interview before acceptance into the programme. Evidence thus far suggests that these medical students eventually integrate well with the conventionally admitted students. St Georges also has an "adjusted criteria" students policy in admitting students from non-traditional backgrounds with a lower entry criteria of 2 "Bs and a C." Kenton Lewis, who is head of "Widening Participation" at St Georges, has stated that the admission of students has not lowered standards and "sometimes it is not the student but the institution that should be open to change." [18]

In keeping with the "Widening Participation" agenda, many medical schools are now engaged in some form of outreach activity with school visits, summer schools, national and regional events, taster days and specific active local partnership with low participation schools including various forms of mentoring. However, the Medical Schools Council admits, there is little evidence available for assessing the effectiveness of any of these initiatives and other programmes designed to widen access to medicine. Indeed, the very fact that there has been such little increase in the proportion of medical students from social class 4 and 5 gaining entry into medical schools, suggest that none of these policies collectively have had the desired outcome thus far.

There are contrary views, however. McManus challenges the ideology behind the "Widening Participation" on the basis of cost of the various schemes that have been implemented, the principles of social justice underlying the premise undermines the principle of equality of opportunity for all, that a diverse population of doctors necessarily better serves a diverse population of patients, and finally reducing overall standards may result.[19] The counter arguments are that social justice is a fundamental principle that overrides maintaining "equal" opportunity, although, as the above indicates, opportunities have never been equal for those who have not had the advantages of independent school/private school education. Diversity amongst doctors is essential otherwise a very narrow view of medicine and management of patients permeates the profession. Diversity also is more likely to overcome the "paternalism" that pervades healthcare and which

is a particularly barbed criticism levelled against doctors. Understanding the predicaments and circumstances leading to some of the unhealthy behaviour of the patients, who form the bulk of those presenting with illness to healthcare, is fundamental to providing a holistic service. Medicine should not be just concerned with treating illness but about empathy and compassion for those who are ill, even though many may have caused their own pathology or at least contributed to it. Understanding that illness is a result of a social construct will never be accepted by some, however. Finally, will standards fall? Which standards-possibly the ability to pass professional exams, initiate and develop research? Do we test for clinical acumen, bedside manner, compassion, empathy, paternalism, arrogance, patient-centredness, putting self-interest above patients' interest, and particularly the interests of private patients over public? Outcome of "standards" evaluation will need to be evaluated with longitudinal studies by HEFCE and similar bodies. In the main, Medicine is much more about managing the routine rather than advancing the frontiers of science although, of course, the latter is absolutely essential. Conceivably that is why so many doctors become bored in their mid-careers and seek other outside interests.

In view of all the above impediments, is there any place for a charity whose aim to improve medical school entry for those from socio-economic disadvantaged backgrounds? Clearly as the Founder and Chairman of a new charity, Aequitas UK, I believe there is. Aequitas acknowledges that disadvantage starts early in life and that only national government can create the right environment and institute policies that can improve social and educational outcomes for young people in the UK. However, Aequitas aims to focus specifically on improving the chances of academically able young people from socio-economically deprived backgrounds to aspire to gain entry into medical schools. Aequitas will focus on students in their GCSE and "A" level years, ages 14-18 years to:

- raising aspirations to consider medical school entry
- mentor students with appropriately trained volunteer medical students
- developing a network of these young people who might then be able to support each other since there may only be one or two in any one particular school and might thus feel isolated
- address issues of financial disadvantage and constraint to support such young people in the period leading to application to medial school, for example in purchasing appropriate books
- tutoring in interview technique
- arrange summer schools and other courses as necessary
- arrange medical attachments, work experience
- inform of the scope of medicine and the wide nature of the many specialities and opportunities
- if fund raising allows, financial help during the period of study at school and medical school thereby remove the fear of debt from applicants
- mentoring at medical school to reduce risk of students dropping out
- mentor, encourage and support parents of these young people
- work with and within schools in deprived areas
- collaborate with national and local educational, and other bodies with a similar goal

This is a significant agenda and is currently being performed piecemeal by many higher education institutions. Aequitas hopes to tackle these considerable challenges in a holistic manner and accepts that there is no guarantee of success since the charity will be attempting to change the basic social construct of the society in which we live and which has not been substantially changed thus far. The charity aims to work with "Widening Participation" departments in all universities and any individual or any organisation which believes in our mission statement. Whilst the charity is based in Liverpool and most of the Patrons and Trustees live and work in the North West of England, its goal is to be UK wide. Clearly this is not the best time to seek charity funding support for such a venture but is there any "best time"? In fact, this is very much the most appropriate time since the ominously gathering clouds of further financial constraint will be a huge disincentive to students from poor backgrounds who aspire to university. Universities were informed of impending "savings" of £449m that had to be made next year by the last Labour Government and further cuts will be on their way, possibly amounting to over 1 billion pounds over the next few years.

Aequitas is seeking to enlist the help of any professional who wishes to support its core aims and work along with it to achieve its goal. If you are interested, please contact me by email at ali.bakran@rlbuht.nhs.uk. The website of Aequitas is www.aequitasuk.org. I look forward to hearing from those of you who believe in a fairer society based on social justice with any suggestions, criticisms, advice, offers of help and support – and even financial contributions!

ALI BAKRAN
Chairman of Aequitas
Consultant Transplant and Vascular Surgeon
The Royal Liverpool University Hospital

Refs. Space precludes publication of the list of references here but it is available electronically on request

AN NHS BEYOND THE MARKET

This Roundtable Conference, held at BMA House on 14th April was previewed in the March Newsletter Harry Keen, John Lipetz and I attended, representing respectively the NHS Support Federation, KONP and NHSCA.
The event did not, at least for me, live up to expectations so I prepared the following notes for my immediate colleagues on what I thought had gone wrong.

Despite a great deal of time and effort this has not turned out as planned, for a variety of reasons

Timing The date slipped into early April and was then delayed again to accommodate Will Hutton who had accepted an invitation to chair. He then withdrew at short notice

The Panel

Some individuals unavailable and some organizations unresponsive

Some organizations initially expressed interest but failed to send rep (RCGP, TUC)

RCN initially involved but pulled out without explanation

Expected panelists did not appear on the day (Allyson Pollock sent apologies due to family illness)
Zoe Gannon (Compass) – no explanation.
Panel was therefore reduced to:-

Organisations RCP, Richard Thompson
Patients Association, Katherine Murphy
National Assoc of LINKS, Malcolm Alexander
Unison, Mike Jackson

Individuals Ann Lloyd (former CEO NHS Wales)
Sally Ruane (de Montfort Univ, Leicester)
Brian Fisher (GP London)
Jonathon Tomlinson (GP London)

together with reps of the 4 sponsoring bodies.

Work in advance Panel members had each been asked to submit a position statement for pre- circulation. Only 4 were circulated, one from a panelist who had already withdrawn

Failure to stick to plan for the day. This had been for the invited panelists to introduce the main points of their position statements in the morning session followed by discussion in which the sponsoring bodies could join. A draft statement was to have been prepared during the lunch break for tabling in the afternoon . Further discussion was then to be aimed at achieving a consensus so that the final statement would have been agreed either by the end of the day or very shortly afterwards.

That this was not achieved was in my view largely due to the idiosyncratic chairing by Nick Timmins who either misunderstood his brief or chose to ignore it. Time was wasted during the morning through his challenging the rejection of the market with the result that the draft statement could not be produced during the lunch break. Although afternoon discussion produced useful ideas on future direction it was not focused on seeking consensus. At the end of the afternoon BMA reps charged with producing the statement expressed confidence that they had sufficient material but the first draft of a consensus statement did not appear until almost a fortnight later, on the evening of 27th April with the stated intention of trying to get it agreed by all participants by 7th May, the day AFTER Polling Day

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Feeling that the draft report did not make the relevant points strongly enough, the three of us (Harry Keen, John Lipetz, Peter Fisher) responded with an amended version as follows.

A round-table discussion of alternatives to the current Market NHS, hosted by the British Medical Association in association with the NHS Support Federation, the NHS Consultants Association and Keep Our NHS Public.

The four organisations, concerned with alternatives to the costly inadequacies and professional distortions of the competitive pseudo-market structure currently imposed on the NHS, sought the assistance of a selection of participants in a round-table discussion to explore fresh, collaborative directions of travel for the NHS in England, bearing in mind the possibility of a new political administration, challenging economic circumstances and even a new public-service philosophy. The starting point for the discussion was a series of position statements addressing issues under the headings of:

- Funding and efficiency;
- Cohesion and fragmentation;
- Planning and commissioning services;
- Improving quality and handling choice.

Participants in the round-table were:

Mr Malcolm Alexander	Chairman, National Association of LINKs Members
Dr Kate Bullen	Deputy Chairman, British Medical Association
Dr Brian Fisher	GP, London
Dr Peter Fisher	NHS Consultants Association
Mr Mike Jackson	Unison
Prof Harry Keen CBE	NHS Support Federation
Mr John Lipetz	Keep Our NHS Public
Ms Ann Lloyd CBE	Past CEO, NHS Wales
Dr Hamish Meldrum	Chairman, British Medical Association
Ms Katherine Murphy	Director, Patients Association
Dr Sally Ruane	De Montfort University
Prof Sir Richard Thompson	Royal College of Physicians
Dr Jonathon Tomlinson	GP, London

The event was chaired by **Nicholas Timmins**, the public policy editor of the *Financial Times* and author of *The Five Giants: a biography of the welfare state.*

The chair first invited the participants to consider a number of questions centred on the theme of "Why is health different" and thus unsuited to a market approach. These questions included:

- Why is profit from health care provision wrong?
- Are GPs not private providers?
- Why now?
- What are the alternatives to a market?

Participants considered that health care provision was indeed different from commodity markets, being founded on principles of social risk-sharing, free access and comprehensiveness and, more recently, continuous quality improvement. The programme of market-based NHS restructuring currently being pursued by government threatens to corrode these fundamental principles and thereby drastically change the face of the NHS. The timing of any questioning of the direction of travel was important. The healthcare market in England was still relatively poorly established and it was critical that service reconfiguration, including more general moves to "care closer to home" and more specific plans for hospital closures, was driven by coherent, evidence-based planning to meet manifest need rather than by 'the invisible hand' of financial competition. Profitability in a health care system should be expressed in terms of health gain effectiveness rather than cash return .A tax-funded health-care system (and no party has currently dissented from this model) had an obligation to ensure that expenditure was aimed at providing and improving the quality of health care and that this was not distorted by providing profit to shareholders. Participants considered that cooperation and integration were wholly, desirable alternatives to a market in healthcare driven by financial competition. These should be the key building blocks in the proposals which would emerge from the round-table discussions.

Discussion

Funding and efficiency

The starting point was an NHS which should continue to be free at the point of use and funded from tax revenues. Participants endorsed distributional arrangements based on equality of access to those in equal need and hence weighted capitation funding for health economies, however they were defined. The present allocation formulae had to accommodate high. market-generated, transactional costs and were not regarded as wholly fit for purpose. They did not, for example, encourage the identification and pursuit of unmet need.

Participants were conscious of the financial position in which the NHS was likely to find itself during the next few years. It was agreed that abandonment of the purchaser/provider separation with its competitive commercial ethos need not necessitate a costly and disruptive reorganisation. This has been effectively demonstrated in Scotland which provides an evidence base for study. We could begin by modifying existing structure(s) This would, pro tem, involve the concept of a local health economy being understood to be either a Primary Care Trust (PCT) area for the generality of services or for specialist and tertiary services a Strategic Health Authority (SHA) The revised, non-transactional relationships between primary care and specialised services being expressed in a new modus vivendi between them.

One of the more costly consequences of the introduction of the competitive market into the NHS has been the arrival and growth of transaction costs. An alternative formulation would seek their dramatic reduction. The replacement of costly bidding rounds and legal contracts with service level agreements would be the basis of service integration. These agreements would involve block funding with some adjustment for volume, incentives, quality enhancement (see below) and cross-boundary activity and obviate the current volume of transactions. While such agreements would also reduce some of the many superfluous, market-generated management costs, the participants were agreed that management as such was undeserving of the pariah status it currently enjoyed. In proper collaboration with clinicians, the management function could generate greatly improved efficiency, quality and harmony.

Cohesion and fragmentation

Cohesion was identified as critical to the future success of the NHS and to health economies within it. It involved reassessment and new regard for:

- Integration of services at various levels within and outside the health economy with its focus on the individual patient;
- Collaboration between providers across disciplinary and adminbistrative barriers;
- The development of clinical pathways and partnerships designed to maximise health gain; and,
- Catalysing all the above by the creative use of organisational and financial recognitions.

Some participants had practical experience of integrated clinical programmes involving cooperation between secondary and primary care providers. They spoke about the benefits of such working and the need for the health service to facilitate greater collaborative working and to explore new health care initiatives. The present arrangements discouraged these programmes since the national tariff was based upon narrowly defined episodes of care with a common price attached in the interests of stimulating competition. Fee for service (so-called payment by results) created accountancy barriers and impeded patient pathways as well as generating perverse incentives in patient referrals.

Planning and commissioning services

Planning of service provision and provider configuration would be at the most local level consistent with economies of scale and would as appropriate align with other services such as social care. Localism would, of necessity, involve some variation in the configuration and supply of services and this would need to be carefully managed to avoid gaming as well as prevent the emergence of postcode lotteries. A significant degree of autonomy should be granted to local health economies to determine the priority to be attached to services whilst accepting that patients would expect that the vast majority of services currently on offer would be provided in all areas to the same specification and quality.

Improving quality and handling choice

Patients are often a vulnerable sub set of the population and they lack the autonomy to always be effective at making healthcare choices. To date, patient choice has only operated on a limited basis. There is a distinction between patient choice as a lever to make providers more responsive and as the capacity for individuals to make informed decisions for their own care. Unfettered patient choice is inconsistent with localism and social solidarity particularly when localism is combined with democratic accountability. Collective choice around patient pathways and local configuration should replace aggregated consumer choice. Policies should aim to deepen patient-professional trust and effective co-production and shared decision making, not undermine them.

Patients, populations and health professionals should be much more involved in the decision-making processes discussing changes in the NHS. This should be achieved by making the NHS more transparent and democratic at every level. It also requires consideration of creation of new education and discussion facilities to prepare patients and concerned members of the public to exercise a substantially more informed and active role in the formulation of local NHS policy and the review of local NHS performance. There should be further devolution of decision making to the local level, more local arrangements which permit democratic engagement and more formal involvement of responsible elected public representatives in local decision making.. The market turns citizens into consumers whereas the NHS is a model which greatly benefits from patients being active co-producers of health care. Modifying existing structures where possible should avoid costly reorganisation.

Conclusion

'Beyond the Market', the NHS model which emerges from the discussion is one in which we should work towards each locality health economy being a single authority, democratically accountable, charged with providing the full range of health care to its population, responding to nationally agreed frameworks of funding and professionally formulated polices on prevention, diagnosis and treatment. Meaningful input from local populations, should contribute to the optimal distribution of necessarily limited funds in accordance with population needs. Funds released by the elimination of wasteful, market-generated transactional costs should be redirected to encourage providers of health and social care to collaborate professionally and to coordinate their activities in the interests of both service efficiency and better individual and community health.

At the time of going to press no final version has been issued. It is still under consideration at BMA House as is the proposed "release" statement we offered:-

'An NHS Beyond the Market'
A BMA-sponsored Round Table looks forward to an English NHS united by professional aspirations rather than fragmented by commercial competition.

In April 2010, the British Medical Association, responding to widespread professional and public dissatisfaction with the growing and costly conversion of the English NHS into a commercial pseudomarket, convened a Roundtable Conference of concerned individuals and organisations to consider alternatives to the market in the English NHS.

NHS performance had certainly improved over the past decade but much of the vast increase in treasury funding was being consumed by the high managerial, administrative and transactional costs of running the market, estimated at £14 billion/year. Much of the new cash left the NHS and went to private concerns. The return in health gain on this immense investment was disappointingly small.

The cost of the market was also to be measured in its fragmentation of the NHS. For example, the separation between so-called 'purchasers' and 'providers' of health care created barriers between general practice and hospital care, between hospitals and between services which were to the detriment of to patients. These market-imposed, transactional structures generated enormous accountancy and commissioning costs recently heavily criticised by the Parliamentary Health Select Committee.

This costly and counterproductive purchaser/provider separation should be abandoned. The market structure should be replaced by planned and coordinated health care provision which could be implemented without major organisational upheavals as has already been achieved in Scotland. For the time being, national, planning would be centred on Department of Health/NHS Executive which would set national goals and standards and determine Regional resource allocation. Regionally, Strategic Health Authorities would assume further responsibilities for coordinating services and their integrated development in the Regions. At Locality level, existing Primary Care Trusts, reinforced by local democratic representation, would be responsible for local service agreements, allocating resources to primary and social care and to hospital and specialist services according to locally determined patterns of need.

The very large sums of money released in due course by the abandonment of the NHS market should be redirected to frontline NHS clinical needs. This will be essential to help ease the financial constraints likely to be laid upon health and other related public services in the coming years.

Finally, (for the moment) we have written as follows to Hamish Meldrum

Dear Hamish

Once the essential messages have been extracted from our recent Roundtable would it be possible for the BMA to move on to the next stage and to mount a large-scale conference, say in Manchester, Birmingham, Liverpool etc addressing the general issue of ***The NHS of the future; what the public wants; Debate the results of a BMA Roundtable.***

We are presently being submitted to a rash of very expensive (and therefore rather exclusive) NHS 'Conferences', one-sidedly addressed by market-adherents (most of them health care politicos, King's Fund establishment, marketeers and managerialists almost to a man or a woman) with the public or the professionally favoured alternatives little if at all expressed.

If the right sort of messages are distilled from our Roundtable discussions, we could, with the nationally respected name of the BMA (and perhaps in this post-election period supported by its NHS Together allies) mount a powerful counterblast public Conference around them to give voice to what are clearly popularly held ideas - and not charge nigh on £1000 for admission.

Under some general title like "Future of the NHS; The Public and the Professionals Speak", against the background of likely NHS cutbacks and acceleration of privatisation with the new administration, it could attract country-wide support from concerned health professionals and members of the public. It might even strengthen the hand of those now in the political opposition, looking for fresh popular policies.

If the Labour Party intends to 'engage more closely with the people' it should certainly hear their views on commercialisation and privatisation of the NHS. As ever we stand ready to offer as much help as we can muster in getting these issues out for professional and public debate.

Warm good wishes

Harry Keen for NHS Support Federation
Peter Fisher for NHS Consultants Association
John Lipetz for Keep Our NHS Public
Ron Singer for Medical Practitioners Union

We have had a friendly reply, that our proposal will be considered, but it does not appear that any early action is likely. We will therefore be considering what further steps can be taken

PETER FISHER

ELECTION TO HEALTH BOARDS IN SCOTLAND

The Scottish Health Campaigns Network came into being in a climate of unrest among communities throughout many parts of the country where people felt that Health Boards were implementing changes to the delivery of health care with little involvement by those who would be affected by their decisions.

Shortly after taking office, the current Scottish Government reversed some of the contentious decisions made by the previous administration and took steps to improve meaningful consultation with communities.

In an attempt to introduce more democracy to the structure of Health Boards, a Bill was drafted in March 2005 in which it was proposed that a number of members be elected to Health Boards in addition to those appointed by the Cabinet Secretary of Health and Wellbeing. The proposal was put out for consultation and there were 160 responses from individuals and organisations. The proposals were supported by 85% of those which responded, amongst which was The Scottish Health Campaigns Network — indeed the Chairman, Dr Robert Cumming, was selected to give evidence to the Health Committee of the Scottish Parliament in support of the proposal.

Those which opposed the proposals accepted the need for improvements to be made in communication between the Boards and the public, but Dr Dean Marshall, of the BMA Scotland, took the view that an alternative approach to this end would be more cost effective than diverting money from patient care.

Others were concerned that Boards would experience difficulty in implementing national policies in the face of local issues and it may come as no surprise to learn that of the 14 Boards in Scotland, five were opposed to the proposals and a further five expressed reservations.

Would 'single issue' candidates prove to be a problem? Would there be sufficient interest to produce suitable candidates and should there be a majority of elected members? These were only some of the views expressed in responses to the consultation document.

The initial Bill which was introduced as a Private Member's Bill by a Labour member was originally defeated by the Lib. Dem/Lab coalition but reintroduced by the current SNP Government which decided to trial the exercise. Two pilot elections are taking place in May/June of this year, by postal ballot (to reduce cost), one in Fife* and the other in Dumfries and Galloway.

Will there be sufficient interest?

In Fife, 61 candidates have entered the field for 12 elected places, while no less than 70 have put themselves forward for the 10 places on NHS Dumfries and Galloway. A delegate from Fife, and who forms part of the SHCN, has put himself forward as a candidate for NHS Fife.

Local Councillors, along with publicly elected members, will form the majority in these Boards. The Boards will remain accountable to the Cabinet Secretary.

Some details about the elections:

The two pilot trials are expected to cost £2.6m

People aged sixteen and over will be eligible to vote and to stand as candidates.

No candidate is required to make a financial deposit.

Candidates may produce a 'profile statement' not exceeding 250 words.

No candidate or his/her agent may spend more than £250 in the electioneering process.

Voting will be concluded by 10th June and successful candidates will take their places on the respective Boards with immediate effect.

A single transferable voting system will apply.

The pilot Boards are expected to last for at least two years.

Members will receive an annual remuneration of £8008 plus travel and sustenance expenses and are expected to commit at least eight hours each week to Board activities.

Among the information supplied to potential candidates it was stated that members are expected to balance national policies with local interests. Members will receive training at national and local levels and will be involved in 'decision making' rather than in operational matters.

Boards are to ensure that the patient experience is at the centre of NHS work and that patients and the public are engaged and involved in decision making-particularly in those decisions which affect major designs.

Members are also expected to conform to the UK level on standards in public life (as per the Nolan Committee). Additionally, they are expected to conform to six standards of good governance as defined in the commission on Good Governance in Public Service (chaired by Sir Alan Langlands in 2005).

Many in Scotland (and beyond) will be interested to see the effects of the extension of democracy to the decision making process within the NHS.

It may help to reduce confrontation but at what price?

*NHS Fife

Serves approximately 360,000 people. Employs 8600 people and has a budget of £500m. There will be 25 members on the Board of NHS Fife.

12 hospitals, 64 GP practices, 78 pharmacies, 55 dental surgeries, 43 opticians.

A final note about health care budget in Scotland:

Of approximately £33bn controlled by the Scottish Government, around £10.6bn is spent on health - £10.1bn on the NHS.

MALCOLM ALLAN

Secretary and media contact, Scottish Health Campaigns Network

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ON MEDICAL STUDENTS AND POLITICS

It may be argued that the medical profession is encouraged to feel relatively secure that the NHS, a symbol of comprehensive social security provided by a progressive society, will continue to receive public and thus political support regardless of the incumbent party in power. Politics therefore need not concern the doctor, who merely experiences political reform as yet another set of targets (s)he must achieve- an inconvenience to be balanced against clinical judgement of best interest and ethical decisions regarding just use of limited resources.

There is a common perception that medical students, like the clinicians they learn from, are only concerned with dealing with the patient in front of them - thus indifferent about politics. This simply isn't true. Many medical students are only too acutely aware of the gaping lack of health policy in the undergraduate curriculum. They therefore feel ill equipped to keep abreast of policy decisions and to participate in debates, let alone to help drive reform in the health services as future leaders in our field.

In recognition of this general ignorance, a group of medical students have thus set up Young Civitas for Medics, which organises discussion forums open to medical students across the country on topics such as the structure of the NHS, clinical leadership, clinical decision making and the role of NICE, implications of the recession and comparative health politics. Hundreds of students regularly attend these debates – a testament to how medical students are keen to engage with policy and to shape a better health service as Tomorrow's Doctors. Find out more at http://www.ycfm.org.uk/

SINDY LEE

Medical student, St George's, University of London

POST-GRADUATE TRAINING : ANOTHER "MARKET"

With public concern not unreasonably focussed on the iniquities of the "market" in relation to clinical care it has gone largely unnoticed that the previous government have started to introduce a "purchaser-provider split" in Post-graduate Medical Education.

Postgraduate Deaneries have been responsible for co-ordinating and monitoring junior doctor training within the NHS since1961. Since the introduction of "Calman" training in the 1990s they have also had responsibility for appointment to the specialist registrar grade and the co-ordination of regional rotations. They have "training contracts" with trainees, though the trainees' contracts of employment continue to be held by NHS Trusts. They host regular training sessions for different specialty groups. They supervise annual appraisals and put forward recommendations to PMETB for the award of CCTs.

As if this arrangement were not sufficiently complex already Deaneries have now been instructed that they should no longer provide or supervise training, they should "commission" training from a "lead provider" in each specialty. As usual this initiative is entirely "evidence-free". There is absolutely no suggestion of how the arrangement will be of benefit to trainees, Trusts or the NHS. It is thought likely by a Deanery post-holder to whom I have spoken that much training currently provided free by Trust clinicians as part of their commitment to their specialty will now require payment and involve transaction costs.

The London Deanery decided to jump before it was pushed and has requested bids for lead providers. This has involved a huge investment of time and effort by the Deaneries setting up the bidding process and by specialist clinicians in leading units who are considering a bid.

The main requirement for lead providers appears to be a high level of fluency in management-speak jargon. Here is a flavour of the instructions for potential bidders:

Over the past few years, NHS London, the London Deanery and its training partners have embarked on a journey to develop the quality of medical and dental education in London and ensure it is aligned closely to service needs. There is a common vision that recognises that delivery of high quality care across new care pathways requires a high quality workforce trained to the highest standards. In recognition of this, NHS London is developing and implementing a world class system for commissioning and delivering medical education, as set out in "Workforce for London: A Strategic Framework".

http://www.london.nhs.uk/news-and-health-issues/news/latest-news/expressions-of-interest-sought-from-prospective-lead-providers-of-postgraduate-medical-and-dental-education-for-london

It is a sad reflection on the current state of paranoia in the NHS that no-one directly involved has felt able to write on this subject and this item reflects only my own, probably faulty, understanding of the situation.

It can only be hoped that the new government will be persuaded that this is a ridiculous waste of money – not to mention valuable clinical time - and is of no conceivable benefit.

It is an issue that I feel the NHSCA should pursue.

Janet Porter

REMINDER FOR YOUR DIARY

THE ANNUAL GENERAL MEETING 2010
Saturday 9th October
Bedern Hall, YORK

Now that the outcome of the General Election is known, the Executive Committee has decided that the theme will be how we can best take forward NHSCA objectives in the new political situation.

Invitations are being issued to speakers who can provide information and experience to help us achieve this.

ENTHUSIASTIC PUBLIC SUPPORT FOR THE NHS

The BMA sponsored meeting held on 25th February 2010 at BMA headquarters Tavistock Square was essentially a forum for drumming up support to stop whichever political party wins the imminent election from cutting NHS services in Greater London. It highlighted the fact that whereas the delivery of healthcare by medical and nursing staff is founded on ***evidence based*** science there is no requirement for government functionaries to base their plans on ***evidence based*** politics. We should use that rebuff whenever Management try to introduce their next harebrained policy. The castration of NHS services in the provinces is a different issue and is handicapped by the lack of a national forum to referee fair play.

The audience's commitment to the NHS as a public service and their abhorrence of the imposition of private financial interference with the delivery of care were the outstanding themes. There was clearly great anger and emotion that any government could contemplate the sort of cuts and private outsourcing of services that formed the basis of the "£21bn" proposed cuts to be imposed on London by a "commission" which formulated policy almost entirely behind closed doors.

The public demonstration held in London on 10th April, supported by many of our members, showed just how passionate public service workers are about the NHS continuing with those ideals set in 1948. The message again was "privatisation must be unravelled and interference by central and local bureaucracies, in the way in which healthcare is delivered, must cease". The Chairman of Council of the BMA gave a short, highly pertinent address to the huge gathering which eventually descended on Trafalgar Square. For decades Consultants have had a rather lukewarm relationship with the BMA. Now we are singing from the same hymn sheet. Long may Hamish Meldrum continue to lead the BMA. He deserves our wholehearted support.

Another recent event, which could assist our goals, was the election of Sir Richard Thompson to the Presidency of the Royal College of Physicians. As a longstanding member of the NHSCA, Richard will be in an ideal position to pursue our case with the new Government and convert their electoral pledges into meaningful clinical solutions. Hopefully the new Government will be driven by political consensus and not by party dogma.

One of the many issues which will need to be addressed is the status and constitution of Foundation Hospital Trusts.

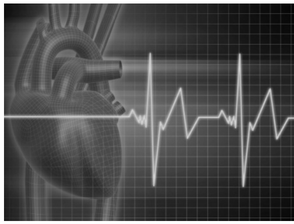
You might have imagined that having recruited membership from the local population, who in turn elect a committee of Governors, that the voice of these people would influence clinical priorities. Forget it. Colchester Hospital Trust, which achieved Foundation status in 2008, has since then strenuously ignored their Governors, treating them as a necessary evil only to be fed the executive decisions for rubber stamping. Nonetheless the Governors did succeed in rumbling the Trust's Chairman who was sacked by Monitor, and the Chief Executive, who in a previous life was the Chief Executive of Ilford's King George Hospital, has decided to "take early retirement". Coincidence? Unfortunately the Governors were unable to question or modify any of the executive decisions made over the past two years – decisions which put profit before clinical priorities. However, with a management board that avoids input from the clinicians, except that of their **appointed**, "radicalised", Medical Director (a retired surgeon), you would not expect their decisions to be clinically focussed. Even the **elected** Chairman of the Medical Staff Committee is not included in their star chamber!

Clearly, Foundation Hospital status and its regulatory body Monitor need to be reformed by properly reasoned legislation which puts patients first and empowers Governors and Non-Executive Directors to challenge the plans of the Management Executive before funds are irretrievably earmarked for schemes which are aimed primarily at making profits. The clinicians must take a major role in developing policy, bury interdepartmental conflicts of interest and concentrate on global clinical priorities. Capital building projects must be funded by the exchequer, not PFI. There is no way that any hospital can pay for a capital building programme by relying on profits which in turn can not be forecast for more than a year or so, let alone decades. How on earth do you factor in quality to such a business case? We must work together and negate the accusation that keeping us collectively on board is as difficult as keeping frogs in a wheelbarrow (courtesy of Jacky Davis).

Let's search for light at the end of the tunnel instead of accepting eternal darkness?

MARK AITKEN

Colchester



WAKE-UP CALL . . .

A red alert film warning of the imminent dangers facing the heart of the NHS,

to be produced for Keep Our NHS Public, Health Emergency and NHSCA

WHY WE NEED THIS VIDEO

"The NHS faces its' most serious crisis in its 62-year history" – states **NHS Chief Executive Sir David Nicolson.**

"This deliberate and concerted withholding of information is secrecy at its worst, and NHS managers at their worst. It is an affront to democracy." **Denis Campbell, Guardian's health correspondent.**

We need a video, a national video, which tells our side of the story on the devastating cuts proposed in our NHS. A video that counters the arguments that hospital, A&E, bed and ward closures need to be cut to make savings to pay for the banking crisis. Think how useful a video could be to expose the 'Emperor's New Clothes' of privatisation, the spin that somehow it is value for money and provides improved services and greater 'patient choice'.

HOW CAN THIS VIDEO BE USED?

This video can be used by national health care campaigning organisations, like Keep Our NHS Public and Health Emergency, by local groups campaigning against hospital and service cutbacks, and by trade unions, professional bodies, such as the BMA, pensioner and other community organisations.

We hope that web links to ***Wake-Up Call*** on our You Tube video site will be widely placed on the websites of the above organisations and groups.

Communal screenings of the video, for example, in Women's Institutes, Mother and Toddler's groups and Senior Citizen's groups could act as a spur to help build wider campaigns to stop the proposed cuts and privatisation.

WHAT WILL WE FOCUS ON?

We wish to make a dynamic video that both exposes the true meaning behind the jargon used by government and NHS management to justify and 'market' the NHS 'reforms.' *What really is a Polyclinic? Can these much- vaunted "Consultant led –urgent care centres" replace much-needed A&Es?*

By interviewing health professionals, patients and relatives we want to show the devastating impact that cuts and privatisation will have on local communities. As Dr Jackie Davies says on the Whittington campaign, *"We know how the hospital cares for you, we were not aware of the extent that you care for it."*

WHICH CAMPAIGNS WILL WE COVER?

We will be contacting local KONP groups to find out what campaigns are being waged in their areas. We wish to include hospital campaigns which have been successful, such as the Whittington in North London and the Horton in Banbury, Oxfordshire. We also want to include the Mid-Staffordshire Hospital, recently embroiled in scandal, and the situation in Manchester and elsewhere.

WHAT DO WE NEED TO MAKE THIS FILM?

Above all, we need support and advice on strong campaigns to help with research and suggestions on interviewees who can touch viewers' hearts and minds with personal moving stories and those who can present powerful, punchy points that can convince with both compassion and humour.

To make a professional film will cost money for production costs, equipment hire, travel and specialist crew so we will need financial contributions. Even with much of the crew and research time donated for free we will still need to raise in the region of £5,000 to cover costs. You or your organisation may have access to great archive footage that we could use.

WHO IS INVOLVED IN THE PRODUCTION?

Peter Cann is a journalist who spent 20 years on the **Oxford Times**. He is Chair of the Oxford and District branch of the **National Union of Journalists (NUJ)** and has been a member of various representative bodies within the union.

Dr John Lister, consultant on the film, was a Founder member of **Keep Our NHS Public** campaign, and a regular public speaker at meetings on NHS issues in England. Since 1984 he has been Information Director/and Editor for **London Health Emergency.** He is an Associate Senior Lecturer at Coventry University. His expertise is in health policy and health journalism (25 years' experience). He is the **winner of the Medical Journalists' Association Tony Thistlethwaite Award 2009** for his book **The NHS After 60: for patients or profits?. Anne-Marie Sweeney** is a professional documentary maker who has made acclaimed films for Channel 4 and numerous campaigning and non-broadcast films. She has a significant history of campaigning against health cuts and hospital closures. **Alice Berkeley** is a graduate of Ravensbourne College in London in broadcasting studies and has worked on films and broadcasts for the **BBC** and **Channel 4**. She has worked on documentaries, dramas, outside broadcasts and short films.

Following consideration of this and other literature, the Executive Committee decided to match the financial support (£500 each) from KONP and Health Emergency

STUDENT LOANS AND FINANCE

For those NHSCA members not in direct contact with students I felt it would be helpful to have more details of the current student funding system in order to better understand its implications – Editor.

Studying for any degree is now expensive. A standard 3 year degree will cost approx £3,200 per year in tuition fees, and students can obtain a maintenance loan of up to nearly £7,000 per year. Studying medicine is even more expensive due to the length of the course.

It is now common for a UK medical student to come out of University with just under £45,000 debt, equivalent to their first two years' salary. This does not take into account any professional studies loan that they may have taken on top of this. Proposals to remove the cap on tuition fees could increase this to as much as £60,000.

The loan system is extremely complex, with money obtainable from a range of sources in amounts which may be unpredictable. For the first four years of their course eligible UK students can apply for a tuition fee loan (approx £3200), a maintenance loan (up to £7000), a maintenance grant (up to £2,906) and a bursary from their University (A St. George's bursary is currently up to £1295). In the final year they can apply to the NHS for a tuition fee grant and to be assessed for a monthly bursary, as well as a reduced rate of student loan.

Graduate entry students, who do a four year course, can apply for NHS funding from Year Two, potentially coming out with less debt, though this does not take into account the debt they accumulated on their first degree or the fact that many have families to support.

The means tested Maintenance Grant was brought in in 2006. Students whose household income falls below a certain amount are eligible to receive this or part of it. For each £1 received in Maintenance Grant, the maintenance loan is reduced by 50p; meaning that students from lower income households should leave university with less debt.

Higher Education institutions each have their own rules for how much bursary they give and to whom. St George's, for example, gives an amount directly related to the amount of Maintenance Grant a student has been granted, on a sliding scale. Some Universities give a set amount to all students, others give bursaries to students from the local area.

If this funding is not enough to cover essential costs incurred by the student, they can apply to the Access to Learning Fund. This is money allocated to each university by HEFCE to assist students who are in financial difficulty, particularly if they are in danger of leaving the course. There are priority groups eg single parents, but each assessment is done in the same way, and the university is able to offer a percentage of the shortfall that the student is experiencing. In the current year St George's was able to offer 40% of the shortfall to the student.

The introduction of Maintenance Grants and Bursaries should mean that fewer students need to apply to the Access to Learning Fund. However, a number of Universities are seeing an increase in the number of students actually starting courses with debt already in place. Students often tell us that they expected to be able to work throughout the course to keep up loan repayments or payments to credit card companies. In reality the intensity of medical degrees often means that students are unable to keep up part-time work, particularly in the clinical years.

As well as applying for loans and grants through the Student Loans Company, we also advise students to apply to charities and external funding organisations. Often the criteria involved in applying for these are very specific, but there are a number of students in receipt of this funding. They can help with tuition fee costs as well as the costs of books and courses.

Student Loans start being paid back when the former student is earning £15K or above. Repayments are made in one of three different ways, according to what type of employment situation the student is in:

- PAYE (Pay As You Earn): if you are employed, student loan deductions are made automatically from your salary
- Self Assessment: if you are self-employed, or a combination of employed and self-employed, you will be responsible for calculating and making your own repayments
- overseas: if you work or are planning to work abroad, you will be required to make a repayment arrangement with the Student Loans Company

The interest rate varies each year (it was 0% in 2009/10). It is linked to the rate of inflation so that in real terms students repay the same amount as they borrow.

ZOE GARRATT

Student Finance & Support Officer

St George's, University of London

THE MARCH AND RALLY
10th April

This event, in defence of the Welfare State and Public Services, was initiated by the National Pensioners Convention who were joined by many Trades Unions, the BMA and other health related organizations, such as KONP and the NHS Support Federation.

NHSCA was represented by about 20 members – apart from others who may have been with different national or local groups.

For the occasion we had an NHSCA banner, featuring the quotation from Nye Bevan which appears on the opening page of the website. Pictures of the banner in action can now be seen there.

It was a gloriously sunny day with a lively crowd estimated at 10,000. Tourists on the open- topped buses got a good view as we marched from the Embankment to Trafalgar Square for speeches and entertainment.

Our banner attracted considerable interest from other marchers and the public, perhaps surprised to find consultants taking part in such activities rather than being – as folklore will have it – on the golf course.

It all helped to demonstrate the breadth of support there is for the NHS and other public services.

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