

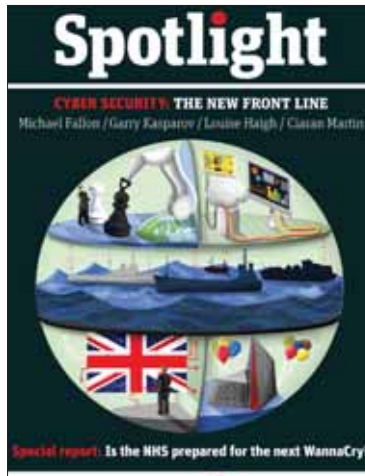
# Spotlight

## HEALTHCARE: THE VITAL QUESTION

Rosena Allin-Khan / Jeremy Hunt / Judith Jolly / Ben Goldacre



# Spotlight



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# Crisis becomes “the new normal”



**D**ecember 2015 was the last month in which the NHS met its operational target for the speed of cancer treatment. This target specifies that at least 85 per cent of patients should wait no more than two months from receiving an urgent referral from their GP to receiving their first treatment. According to the research organisation QualityWatch, in January 2017 more than 20 per cent of patients waited more than two months to begin treatment.

This statistic is a vital indicator for people reading this issue of *Spotlight* not only because it describes thousands of frightened people, recently diagnosed with cancer, being made to wait more than 62 days to receive treatment, but also because it is the one most likely to bear, at some point, on their own lives. Cancer is the leading cause of premature death in the UK; during 2016, the ONS recorded that an average of more than 800 cancer diagnoses were made per day. Both Cancer Research UK and Macmillan have predicted that half of the UK population will get cancer in their lifetime. It is this type of statistic, too, that describes the slow-moving glacier of need behind the urgent demands seen in A&E statistics. While Jeremy Corbyn was right to highlight, in PMQs, the horrifying statistic that 17,000 patients were left waiting in the backs of ambulances in the last week of December, the crises felt each winter are only the crystallisation of far larger and less visible problems growing in the UK's systems of health and social care.

The British Medical Association announced last week that the unprecedented pressure of the “winter crisis” created each year in the NHS would continue into the summer. Dr Chaand Nagpaul, BMA council chairman, said that “we cannot accept that this is the new normal”. But unless issues such as underfunding, wasteful disorganisation, a dearth of skills and a lack of accountability are addressed as quickly as possible, the new normal is something the UK will have no choice but to accept.

## 4 / Rosena Allin-Khan

The A&E doctor and Tooting MP on Labour's pledge to protect the NHS

## 10 / Jeremy Hunt

The Health Secretary outlines his plan for more midwives

## 14 / Reorganising the NHS

Why are Accountable Care Organisations (ACOs) currently the biggest debate on the future of the NHS?

## 16 / A bright future

Lincoln and Sunderland universities are launching new medical schools

## 22 / Ben Goldacre

The academic, author and doctor calls for more transparency in NHS funding

## 26 / Judith Jolly

The Lib Dems' spokesperson for health explains the party's proposal for an NHS tax

### NewStatesman

71-73 Carter Lane  
London EC4V 5EQ  
Subscription inquiries:  
sbrasher@  
newstatesman.co.uk

Account Directors  
Justin Payne  
Elliott Baker

Commercial Director  
Peter Coombs  
+44 (0)20 3096 2268

Special Projects Editor  
Will Dunn

Special Projects Writers  
Rohan Banerjee  
Augusta Riddy

Design and Production  
Leon Parks

Cover illustration  
Sam Falconer



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**A&E doctor and Tooting MP  
Rosena Allin-Khan says the  
Labour Party is aiming to counter  
years of Conservative underfunding  
in emergency services**

# Waiting lists are costing people their lives



**F**or the last 70 years, our National Health Service has been part of the fabric of our society, providing care and support to us during some of the most desperate days of our lives. However, the decisions made by successive Conservative-led governments have left our NHS underfunded and overwhelmed.

Since 2010, the number of people waiting longer than four hours in A&E has soared. In 2016-17, 2.5m people waited four hours or longer in A&E, compared to just over 350,000 in 2009-10. As an A&E doctor, I have seen first-hand the extreme pressures that our NHS has been under in the winter, and the effect this has had on all those who work within it and the patients who rely on it.

The issues start with patients' access to GP appointments. One in four people now wait a week or more to see or speak to a GP or nurse. Sometimes, they don't

get an appointment at all. This has a massive knock-on effect on treatment times – waiting lists have soared with over 4m people in England waiting for treatment.

Cubicles are full because there is no space to move people onto wards. The wards are full because the social care system is completely inadequate in supporting people to return home. Just as we witnessed over Christmas, when all beds are taken, ambulances queue up outside hospitals. They are full of patients who can't get the hospital care they need and paramedics who can't do what they're trained to, treating the next person who has called 999.

It makes my heart sink when I hear of ambulances stacking up outside hospitals. Patients are not getting the care and support they need, and our staff are having their hands tied. Labour has found that over the course of the winter crisis 100,000 patients were stuck in the



back of ambulances for over 30 minutes, unable to be admitted into A&E, and leaving the paramedics unable to answer emergency calls.

The reality is that people are increasingly forced to come to A&E who shouldn't have to be there. Patients who can't access GP appointments, people who have had to wait too long for a hip replacement and are now in severe pain, queuing up together with the emergency cases – from heart attacks to road traffic accidents. It is simply too much for the resources that are

## Frontline staff are stretched to their limit

currently provided.

A pressing crisis in mental health has been brewing for a number of years under this government. Spending on mental health fell by £600m between 2010 and 2015, and there are over 5,000 fewer mental health nurses today than in 2010.

In my MP advice surgeries, I have had mothers come to me explaining that their families are being torn apart because their children cannot access the mental health treatment they so urgently need. Teachers locally have told me that eating disorders are on the rise and the age at which these symptoms are presenting is getting younger and younger. All the while, resources are being cut, and frontline medical staff in hospitals do not have the time to delve past the presenting problem to tackle the cause.

As a doctor in 2018, you often find that while you may have time to treat, you

do not have time to cure. It goes against what we were trained to do – we were trained to cure a person, which stops the need for them to return, reduces queues, in the long run saving the NHS money. That is why I am pleased the Labour Party is committed to making sure that mental health is given the same priority as physical health; to ring-fencing mental health budgets and ensuring funding reaches the frontline.

The chronic shortage of hospital beds puts pressure on waiting lists and impacts the health of patients while they wait for operations. The shortage of operating theatres and resources forced the Prime Minister to tell the House of Commons that all non-emergency operations would be cancelled in January, further delaying long-awaited operations and adding yet more strain to emergency departments around the country.

In the largely uneventful Cabinet

# Underfunding social care is a false economy



reshuffle in January, “social care” was added to the Health Secretary’s title. One of the most significant pressures impacting our NHS is the lack of adequate social care and the fact that some local authorities across the UK are on the brink of bankruptcy. Cuts to adult social care budgets are expected to reach £6.3bn by the end of this financial year and the government has completely failed to set out a proper plan to fund it.

The government’s underfunding of social care is a false economy, owing to its negative impact on our NHS. People are unable to leave hospital because of the inadequacy of the social care system. Elderly patients in hospital beds have told me that they feel like a burden because they have nowhere to go where they will receive adequate care. This is symptomatic of a failing system.

The success of our NHS hinges on the political choices of the government. The two fundamental political choices that have led to a perfect storm are the Lansley Health and Social Care Act 2012 and the lack of adequate funding. The Lansley Act was slammed at the time by many, including people within the Conservative Party. Many professionals, Department of Health officials, and fellow MPs I speak to agree that it has been a disaster.

The restructuring that has taken

place across our NHS over recent years has led to enormous fragmentation across the board, with private sector providers contracted out to deliver parts of local services. NHS staff work day-in, day-out, to care for people during the worst days of their lives, but that job is becoming increasingly harder as wards are crumbling around them. Labour plans to halt and review the government’s Sustainability and Transformation Plans, and to involve local people to ensure that any future changes will focus on patients’ needs.

Labour’s plans for the future of our NHS sadly have to again repair the damage caused by a Conservative government. We have done it before and we will rise to the challenge again for the benefit of patients and staff. We will take one million people off waiting lists and guarantee that patients can be seen within four hours in A&E, ensuring that safe staffing levels are enshrined in law.

Our NHS is ingrained in our society and its success is down to the doctors, nurses, porters and countless other staff who work extremely hard to deliver the best service they can. For them it is a vocation and for Labour it is part of our inherent philosophy. We will save it again by taking it off life support and into a healthier future for us all.

# Protecting the public has never been so important

**Margaret Coats, chief executive at the Complementary and Natural Healthcare Council, explains how the CNHC's Accredited Register is raising public healthcare standards**

**I**n its latest report on the wider public health workforce, the Royal Society for Public Health (RSPH) is adamant that the UK must make use of every opportunity to improve public health and make progress on health priorities such as reducing obesity and smoking. The public health challenges in the UK – especially during a time of unprecedented burdens on the NHS – remain deep-rooted and severe.

*Untapped Resources: Accredited Registers in the Wider Workforce* comes down firmly in favour of complementary therapists on CNHC's Accredited Register playing a much bigger role in improving public health in the UK and reducing the burden on an overstretched NHS. Page eight of the report says: "Practitioners registered with CNHC support public health by encouraging their clients to make a range of lifestyle changes. These include improvements to diet and nutrition, support with giving up smoking and losing weight, support with reducing stress, improving sleep, managing pain and other symptoms, as well as overall enhancements to wellbeing. All CNHC registrants are committed to enhancing the UK public's health and wellbeing."

The report goes on to note this support has great impact because of the unique relationships of trust that CNHC registrants build with their clients. In much of the complementary healthcare workforce, comparatively long sessions are typical, with 94 per cent of practitioners averaging over 40 minutes per appointment. The engagement that practitioners enjoy means they can offer

a breadth and depth of support over time and individuals are made to feel they have an open door to return.

Because of this, clients often respond by talking about issues they might be reluctant to bring up in a rushed or crowded GP surgery.

The public polling carried out by RPSH underlined the importance of the Accredited Register practitioner's role in making the client feel comfortable having conversations about lifestyle health issues. The most popular reasons given by the public for feeling positive about having a healthy conversation were if the practitioner has a non-judgemental approach, and if they are relaxed and not rushing the consultation.

Many of the challenges identified by practitioners were, at root, problems of ensuring the accessibility of their services to the public. One important aspect of this was overcoming the financial barrier, since the majority are only able to receive clients privately. This places those from lower socio-economic groups at a particular disadvantage, with people in the most deprived areas of Britain living on average 20 fewer years in "good health" compared to those that are in the most affluent areas.

In its focus on mitigating access barriers, the RSPH report makes two key recommendations:

1. Employers to consider ways of easing employees' financial barriers, by incorporating access to the services of Accredited Register practitioners as part of their health and wellbeing strategy.
2. Accredited Register practitioners to be able to refer directly to NHS healthcare professionals. By providing this referral pathway, patients would no longer be forced to make time-consuming GP visits just to secure the referral to the NHS funded healthcare that they need.

The report was published in November 2017, so it is still very early days in respect to discussion of, and progress with, these important findings.

**For more information, please visit: [www.cnhc.org.uk](http://www.cnhc.org.uk)**

IN ASSOCIATION WITH



**BY THE NUMBERS**

# Mental health in young people

**35-50%**

The World Health Organization (WHO) estimates that between 35 per cent and 50 per cent of people with severe mental health problems in “developed countries” receive no treatment.

**51%**

More than half of young people in a survey by YouGov believed that they would lose friends if they were diagnosed with a mental health problem.

**10%**

According to Young Minds, in an average class of 30 school children, three will have a diagnosable mental health problem.

**30%**

According to the mental health charity MQ, only £26m a year in the UK is earmarked for mental health research specifically on young people.

**1,660**

The Office for National Statistics found that 1,660 people under the age of 35 in the UK committed suicide in 2015-16 – 103 more than in 2014 and 58 more than the previous highest record of 1,602 in 2011.





## 10 years

The Centre for Mental Health says it can take a decade for many young people to receive help after showing their first symptoms of mental illness. Opportunities to help are often missed – due to a lack of resources or an unwillingness to seek help – and action is usually “reactive” rather than “proactive”.

## 75%

According to MQ, three in every four mental illnesses in the UK are onset before a person reaches their 18th birthday, while half of mental health problems in adult life (excluding dementia) start before the age of 15.

**Jeremy Hunt, Secretary of State for Health and Social Care, explains why the government is prioritising training thousands of new midwives for the NHS**

# How can we make the NHS the safest place in the world to give birth?



**I**'ll admit that I was a little puzzled when I first met Carl Hendrickson. He'd come to a discussion I held with families affected by poor care at Morecambe Bay in Cumbria, and I'd wondered why he had insisted on bringing his young son with him to my offices.

He sat down and calmly told me his story. He spoke about how he met and fell in love with his wife, and of the joy they felt together when she gave birth to their first child. And then he described the nightmarish series of events that led to him losing both his wife and a second child because of poor care.

Carl explained that he had brought his son because he wanted him to see with his own eyes that he had taken his concerns right to the top. He's one of many incredible campaigners, including others like James Titcombe, Melissa Mead and Sue Morrish, who have chosen

to relive their personal tragedies in the hope of making the NHS safer for us all.

Earlier this year, we heard why this work is so desperately needed. A global report by Unicef found the UK ranked 27th among high income countries on a key index of maternity safety – namely, how many babies die during the neonatal period of up to 28 days after birth. The study also estimated that four in five neonatal deaths around the world could be prevented.

From faster identification of sepsis and other infections, to better information about spotting potentially fatal complications during pregnancy, the NHS is working hard to improve its own record. Thousands of health professionals have been working together to improve clinical standards, resulting in a 15 per cent drop in the stillbirth rate since 2010.

But there's a long road ahead if we



want to catch up with the safest countries to give birth (currently Iceland and Japan) and that's why last year I brought forward the challenge to the NHS of halving the rate of stillbirths, maternal and neonatal deaths and brain injuries occurring during or soon after birth from 2030 to 2025. If successful, this would save an additional 4,000 lives a year and make us one of the safest healthcare systems in the world.

#### **So how will we do it?**

One of the most important things we can do is to make sure that, when something does go wrong in the NHS, we understand why and we learn lessons from it. From April, around 1,000 families experiencing a stillbirth, neonatal or maternal death or severe brain injury during labour will be guaranteed a wholly independent investigation from experts in the newly

established Healthcare Safety Investigation Branch. We are also going to look into allowing coroners to conduct inquests into stillbirths – at present, coroners can only investigate the deaths of babies who show signs of life after being born, not full-term babies who died during labour. We are exploring ways to make sure more parents get the chance of a full explanation.

The second important thing is that the NHS responds more openly and compassionately to families who have experienced child loss. At present, extraordinarily painful cases are being made worse because parents often experience a defensive and blocking response from the NHS when they raise concerns about care.

Many feel that their only recourse is to pursue their case through the courts, which means that the opportunities to learn and apply lessons quickly after

#### **BY THE NUMBERS**

## The NHS and maternity safety

# 660,000

– the number of babies born in England in 2016

# 2.6

– the number of babies per 1,000 who will die within the first 28 days

# 1 in 6

– the proportion of pregnant women who will go on to have a miscarriage

# 27th

– the UK's ranking in Unicef's global rankings for newborn deaths

# 50%

– the government's target for reduction in stillbirth, neonatal and maternal deaths

# 4,000

– the number of lives that could be saved if this target is met

# 650

– the number of extra midwives who will be in training from next year

## Women who know their midwives are less likely to miscarry



an error are lost as a result of protracted legal processes.

We are therefore aiming to introduce a new “rapid resolution” scheme offering families of children who experience avoidable severe brain injury faster access to compensation and support without going through the courts.

The sad fact is that some baby deaths cannot be prevented, but what we can do is make sure the NHS gives grieving families the support they need to cope with such unbearable personal tragedy. And so thirdly, we are going to look at what more we could do specifically to support parents who have late miscarriages of up to 24 weeks.

In particular, I want to look at making sure these families have the right to certify and register their babies on official records – something that can mean the world to grieving parents – as well as making sure mothers get the same package of care, including bereavement support, as those experiencing a stillbirth later in pregnancy.

Above all, for a woman giving birth, the relationship with her midwife is absolutely crucial to making her feel safe at one of the most vulnerable

moments in her life. That’s why last month I announced a plan to give all women care from the same midwives throughout their pregnancy journey and birth.

The statistics are clear – women who get to know their midwives personally are 19 per cent less likely to miscarry, 16 per cent less likely to lose their baby and 24 per cent less likely to have a premature baby. Some hospitals already follow a “continuity of care” model, but we want this to be the case throughout the NHS, and to do so we will be expanding midwifery training places by 25 per cent from next year, with plans to train 3,000 more over the next four years.

None of these measures, I realise, can help bring back a single baby who has died, but they will mean that the NHS responds to these unfathomable tragedies in a kinder, gentler and more thoughtful way, and learns the deep lessons that can prevent similar tragedies in the future.

And this, ultimately, is the best tribute we can possibly pay to Carl and many other bereaved families whose simple request is that the NHS listens and learns from the mistakes that it has made.



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# Are ACOs the beginning of the end for the NHS?



**ACOs (accountable care organisations) are the latest three-letter acronyms to join the NHS lexicon.**

**Anna Charles, senior policy adviser at the King's Fund, explains what integrated care is, and why it's widely feared**

**C**onstraints on NHS funding and rising demand from a growing and ageing population have put the NHS under enormous pressure. The response requires the NHS to work differently by breaking down barriers between services, to integrate care around people's needs and to place greater emphasis on the prevention of ill health.

Developments in integrated care are taking different forms. A variety of terms are used to describe these arrangements and they are often used interchangeably, leading to confusion. Integrated care systems (ICSs), previously known as accountable care systems, bring local NHS organisations and local authorities together to plan and commission care for their populations and provide overall system leadership.

They evolved from sustainability and transformation partnerships (STPs), which were introduced across the country in 2016, but are more advanced in their ability to work collaboratively and are given more freedom by the NHS to decide how they manage resources.

At the same time, groups of providers of NHS services are also coming together

in many areas to integrate the way that care is delivered. This may include hospitals, community services, mental health services and GPs, as well as social care and independent and third-sector providers in some cases. We refer to these as integrated care partnerships, and the areas they cover are usually smaller than those covered by an ICS.

Accountable care organisations (ACOs) are a more formal version of integrated care partnerships that could be established when commissioners award a long-term contract to a single organisation to provide a range of health and care services to a defined population following a competitive procurement.

NHS England is developing a new contract to be used by commissioners wishing to go down this route, but ACOs do not yet exist in practice. Nevertheless, these developments have been met with some concern and prompted two separate legal challenges.

## **Why are ACOs so controversial?**

Two key factors have driven these concerns. The first is that the language of accountable care originates in the



## Collaboration is the NHS' best hope

SHUTTERSTOCK/HILCH

United States, raising concerns that ACOs signal a move to an “American-style system”. But these concerns are largely unfounded. The aspect of ACOs that has been adopted from the US is the idea of holding providers to account for improving outcomes for a defined population. Other elements, such as who pays for care and delivers it, would not be copied from the US. The principles of a universal health system, funded through taxation and available on the basis of need to pay, wouldn’t be affected.

The second factor is that the proposed contract would involve the use of competitive procurement, raising concerns that this would allow private companies to compete to deliver NHS care. In practice, public-sector providers are more likely to be awarded these contracts, as a successful bidder would need to demonstrate that they have the capability and experience to deliver a wide range of NHS services, and that other local providers – including GPs – are willing to work with them. The area furthest ahead in its plans to use the contract, Dudley, has identified two NHS trusts as the preferred providers. However, these arguments offer little reassurance to those who doubt the capability of commissioners to manage procurements of this nature or the motivations of some providers.

In response, NHS England has decided to delay the use of the proposed ACO contract, and this offers an opportunity to listen to the concerns of campaigners and communicate why the contract is needed. At The King’s Fund we have argued that much more needs to be done to explain what the contract would add to existing ways of integrating care and, indeed, whether it is needed at this stage in the development of integrated care.

### Progress in integrated care systems

Ten areas have been selected by NHS England to lead the development of integrated care systems and they have been working to put in place the structures that are needed for an ICS to work. For example, they are forming boards, appointing leaders to oversee their systems, and making agreements

to share money and responsibility for performance. They’ve also been working to change and improve how care is delivered, for example by introducing multi-professional community teams to support older people in the community and avoid unwanted hospital admissions.

Recent guidance from the national bodies makes clear that ICSs will become increasingly important in planning services and managing resources in the future. The areas that are operating in this way will be given increasing freedom over how they manage their resources, and other systems will soon be joining the programme if they can demonstrate their readiness to do so.

### What does all this mean for the future of the health system?

This represents a different way of working for the NHS with an emphasis on places, populations and systems rather than organisations. It marks a shift away from policies that have encouraged competition and towards an approach that relies on collaboration between the different organisations delivering and paying for care.

Working in this way is not easy in the context of the Health and Social Care Act 2012, which was primarily designed to promote competition. Changes in legislation will be needed to bring the statutory framework into line with the priority being given to integrated care, but there is no prospect of this happening in the short term because the government lacks a working majority and Brexit is dominating the timetable.

Integrated care is not a panacea and national and local leaders will need to be realistic about the time it will take for these developments to deliver results. They will not remove the significant operational and funding pressures facing the health and care system in the short term. However, The King’s Fund believes the development of integrated care systems should be supported, as they offer the best hope for the NHS and its partners to provide the integrated health and care services required to meet the needs of the growing and ageing population now and in the future.

From this September, five new medical schools will open around the country. **Matt Warman MP** and **Julie Elliott MP** describe the difference this will make in their constituencies

# Better by degrees



**Matt Warman MP**  
(Boston and Skegness, Con)

Boston and Skegness is the constituency that – infamously – voted more vigorously than anywhere else to leave the European Union. More than three-quarters of voters turned out for the referendum, and 76 per cent of them wanted to leave. What was the specific reason cited most often for doing so? It was either “I can’t get an appointment at my GP”, or “A&E is full to burst”. These answers were proffered as an example of the pressures stemming from immigration, because the lens through which Brexit was seen on the ground was as often as not, the NHS. No wonder,

then, that big red bus was so powerful.

On talking to local NHS staff, however, it wasn’t immigration per se that had challenged the system most profoundly: it was the difficulty in recruiting staff to rural and coastal Lincolnshire, and it was the blessing of a population that is living longer and longer. Some pointed out that prior to the surge in immigration, the less and less used maternity unit at Boston’s Pilgrim Hospital was on a trajectory that would have threatened closure as it would have become harder to run safely. Hugely dedicated local NHS staff were being put under increasing pressure, and ultimately the limited number of doctors training in the system were more likely to go to larger hospitals where opportunities to teach or specialise were hugely attractive.

So from even before I was elected in 2015, and well before the referendum, it

was obvious that Lincolnshire needed a radical shot in the arm to alter patterns of recruitment for doctors. That, said the universal consensus, was a medical school based in the county. Still, it was truth be told a campaign I signed up to lead in Parliament with little genuine hope of success. Most recently, in every departmental Health Questions in the Commons, it felt as though every MP in the place stood up solely to say that their constituency deserved a slice of the government’s plan to increase medical school places by 1,500.

The government’s criteria, however, did dictate that it was places that were “under-doctored” that would be given a first look at the new scheme, and there was a particular focus on increasing GP and mental health services. All these the Lincoln University bid did, and by signing up to do the scheme jointly with the well-established Nottingham





University Medical School a good deal of bureaucracy was cannily avoided. It was rightly not enough to say that Lincolnshire needs more doctors. Doctors tend to practice near to where they train; ergo we get a shiny new facility. Knowing that Lincolnshire fitted government criteria so well, I was conscious that the role of a local MP must surely be to make sure the bid accurately reflected that reality.

Some 6,000 medical students start their training each year, and Jeremy Hunt's 25 per cent expansion of that number by 2020, hand in hand with a similar expansion in nursing training, is a transformational exercise for the NHS. It addresses the long-term deficit in doctors that we've locally sought to plug with overseas recruitment and a £20,000 golden handshake for GP trainees, and demonstrates that for all the talk of the NHS needing increased

investment, the challenges don't simply require extra cash. Indeed, with more doctors in the system there are likely to be lower bills thanks to fewer locums with their higher wages, and less stress on the existing workforce resulting in sickness and absence. It's a classic case of investing to save. And on the way there's a commitment to increase the diversity of medical students, attracting more applicants from state schools and making the typical doctor look a little and sound a bit more like the typical patient.

So alongside Lincoln, Sunderland, Lancashire, Chelmsford and Canterbury each get new medical schools, while other existing ones expand. All this, of course, is only possible if there is the money to fund that expansion, and Conservative stewardship of the economy has delivered that. These are announcements that defy the accusation that the government is

consumed by Brexit, and indeed, they also address concerns that leaving the European Union might further challenge recruitment. That, in truth, remains to be told but inarguably expanding medical schools can do no harm.

Speaking personally, however, there's a second truth: voters routinely tell their MPs that we achieve nothing for the man or woman on the street, and rural areas each claim to be forgotten counties. Every one of these new medical schools demonstrates not only genuine commitment to the NHS from this government, but also the fruits of huge coalitions of MPs, healthcare professionals, university staff and others, all making a single, local case to Whitehall. This is a plan that will take a number of years to bear fruit, but it is also one that will last for generations – and it's an example of long-term thinking on healthcare from public servants across the board. More of that, hopefully, is to come soon.



## **Julie Elliott MP** **(Sunderland Central, Lab)**

Sunderland University's new medical school is set to open its doors in September next year, as part of the government's expansion of medical training. Our city will welcome 50 students in 2018 and 100 students in 2020, in a bid to boost the number of doctors in the North East.

Sunderland won funding after taking part in a bidding contest against other applicants, recognising our track record of excellence in medical sciences and nursing education. The development sends a clear signal that students don't have to go to Newcastle or other cities for top-class medical training. Our course will rival the best in the country, incorporating extensive exposure to real-life clinical settings, and students will benefit from stimulation suites

## Sunderland lost 25 per cent of its GPs in three years



Sunderland will have a new medical school this September

located on site at the school's Living Lab – an amazing state of the art facility at the university that is already used by Sunderland Royal Hospital and others for training purposes.

While our NHS in Sunderland has much to be proud of, with our Eye Infirmary and Children's Centre acting as regional hubs, it's no secret that we have problems attracting medical professionals. This bold step forward seeks to change this, and to address the disappointing drift to the south of newly trained doctors. Studies show that doctors tend to stay in the areas where they train, so we should be optimistic that our region will see more medical professionals to deliver high-quality care and ease the pressure on dedicated NHS staff who are already working in overstretched hospitals.

Our university has always played a crucial role in supporting our community thanks to the hard work of vice-chancellor Shirley Atkinson and Professor Scott Wilkes, and this new development is no exception. Crucially, the school will specialise in GP and psychiatric training, complementing existing medical training in the region and addressing the chronic shortage of GPs in Sunderland and the wider North East. Last month, I obtained government statistics revealing that the number of full-time GPs in our city

has plummeted in the past few years, with numbers dropping by 25 per cent between 2013 and 2016. This has left Sunderland with fewer than 140 GPs to serve record numbers of people seeking help from GPs and A&E services.

The school will recruit hugely talented students from the communities in which they live and where they will eventually practice. The university and local council will work closely together to provide an environment conducive to retaining young doctors, creating a new generation of truly local GPs that understand the pressing issues faced by our region.

While this move is good news for Sunderland and the wider North East, the government needs to be doing much more to address the problems facing our NHS in Sunderland and across the country. It will be another six years before these extra doctors have the training they need to work in our community and hospitals, so the government needs to take much bolder immediate action.

We need more support for those doctors already working in our hospitals who are inundated with record patient numbers. It's clear that our hospitals cannot wait six years – our NHS needs proper government funding so that it can deliver the vital services and high-quality care that we all depend on.

# What the NHS can learn from social housing

**David Murray,  
CEO of Kirona,  
says the NHS  
should adopt new  
technologies in  
order to reduce  
costs and improve  
quality of services**

**T**he challenges facing the NHS are well recognised. The continued funding squeeze, rising demand and the need to safeguard quality and data security, combine to exert pressure across the entire system, with none of these factors likely to abate. It's now widely acknowledged that the time for talking about the challenges needs to make way for action.

Despite the NHS employing 1.7m people across the UK and being the country's biggest employer, there are staff shortages across the whole of the NHS, and some particular pressure points in areas where the workforce needs to grow. The aspiration to move services out of hospital to provide care closer to home, and to offer new models of care delivery, depend on an expanding community care workforce.

Such a system is something that is being implemented by some healthcare providers and they are benefiting from savings, improved patient care quality and increased workforce morale. However, healthcare providers adopting these systems are relatively few in number. Conversely within other industries, particularly social housing, it is the norm. The system they use is called field service management technology.

Just like healthcare providers social housing providers such as local authorities and housing associations have to plan, schedule and mobilise their community-based workforce; in the case of social housing they tend to be looking after properties rather than people. However, the same need for customer data security applies. They also have the

same need to reduce costs, improve productivity and increase quality of service for the end user – generally to do more with less.

## **So how does it work?**

Patient appointments can be planned and scheduled using dynamic software. This ensures the right practitioner with the right skills is appointed to either a home visit or elsewhere, which is different to rostering. Rostering ensures that you have enough people to fulfil the demand at any point in time.

The practitioner is then able to see the jobs assigned to them for the day ahead via a mobile workforce application. Encrypted, patient records and relevant information are available, securely to them via the mobile workforce application. Rather than having to travel back to the office to key in patient notes regarding the visit, it can be done via the application during the visit.

Mobile Device Management software can be applied to the mobile device the practitioner uses, which enables your organisation to manage and control security policies for each mobile user and protect data while both in motion and when held on the device. This ensures that patient data is secure and in compliance with all healthcare regulations.

Kirona have enabled North Lanarkshire Council to improve its quality of health and social care service, whilst also saving in excess of £1.5m. By implementing Kirona's field service management solutions across its Housing Property Services and Home Support Services the council have been delighted with the outcomes. Together with the impressive cost savings the council has also improved the service for patients receiving care at home via the Home Support Team, as well as their social housing tenants.

Ultimately, the technology exists to meet the challenges of the NHS; it's just a case of when it will be as widely implemented as it already is by social housing providers.

**For more information, please email:  
[info@kirona.com](mailto:info@kirona.com)**

IN ASSOCIATION WITH



# A private solution to a public crisis

The University of Buckingham's **Sir Anthony Seldon** and **John Clapham** discuss the unique merits of its independent and innovative medical school



## Sir Anthony Seldon, vice-chancellor

The medical school started at the University of Buckingham is one of the most exciting developments in medical education this century. The first independent medical school since the Victorian era, it was set up despite medical and educational systems and scepticism, and is now a shining beacon amongst the 34 medical schools in Britain.

The achievement was very much the work of Professor Karol Sikora, the son of the Polish army captain who came to Britain during the Second World War. Sikora spent his career as a restless oncologist, challenging orthodoxy wherever he encountered it. My predecessor as vice-chancellor, Terence Keeley, another contrarian was the other person who ensured that it happened, taking its first cohort of 64 students in January 2015. Demand has been considerable, and this September, we recruited over 100 top-quality would-be medics.

A focus on patients and proactive medical care is a particular feature of the

medical school. We have heard many times that the NHS is a National Illness Service rather than a National Health Service. Entrenched thinking has made the focus much more dealing with illness once it occurs rather than trying to ensure prevention of illness.

Yet so much illness is preventable if people at large ate more fresh food and less stodge, drank more water and less alcohol, inhaled more fresh air and less smoke, and if we enjoyed recreation more through physical exercise than glued in front of a screen.

Those dispensing medicine need to take better care of themselves too. For several years I have witnessed with a wife with terminal cancer, and last month at hospitals with a sick daughter, staff who were too tired, distracted or plain rude to converse in a civilised and pleasant way. If medical professionals do not look after their own physical and mental health better, how can they look after patients optimally? So a focus of the Buckingham Medical School is helping to train our doctors to learn to manage themselves more mindfully.

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MEDICAL SCHOOL

The state-of-the-art Academic Centre is the result of a partnership between Milton Keynes University Hospital and the University of Buckingham



**John Clapham, pro vice-chancellor, health sciences**

The other defining feature of UBMS is that it receives no state support whatsoever. It exists because of the students who pay the same fee irrespective of whether they are overseas or home students, with home students comprising 60 per cent of our cohorts. From 2019, when our first cohort graduates, we will from then on be producing doctors at no cost to the taxpayer. That's right, no cost to the taxpayer. Starting with 60 in 2019 building to over 100 from 2022. The whole setup was funded privately by

## The course is of no cost to the taxpayer whatsoever

the University of Buckingham.

Our operating model is very simple. We pay from the student fees for all of the elements required for high-quality medical education and for placements we have negotiated directly with the NHS Trusts who take our students. The total cost of our programme is under £170k, compared to some £250k the taxpayer has to fork out to produce each doctor. The other things we do is focus solely on delivering high quality medical education and the staff are dedicated to that principle. This attitude is reflective of the whole university which achieved a TEF Gold for its teaching. Our model also means that we can tell our students exactly what we spend their fees on. It is a high overhead, low margin programme so we are not in it for the mega money but as an expression of the pride we have in our university and the kudos of having a medical school.

Half of the revenue from the medical school, despite it being private, goes directly into the publicly funded NHS. In 2018 this will amount to

over £5.5m, well over 10 per cent of the entire university's revenue. This, and partnership with a medical school, brings benefits to hospitals and the communities around them. They can use the money to recruit new consultants to compensate for the time spent on teaching but from a much wider demographic because of the attraction of education to many consultants. Thus the communities around teaching hospitals benefit from the higher calibre applicants for consultant jobs.

We have built up very strong and positive relationships with our Trust partners. Our first partner, and hub hospital, was Milton Keynes NHS Foundation Trust, now Milton Keynes University Hospital. In February 2018, a state-of-the-art Academic Centre, designed by Philip Bodie of Fielden Mawson, was opened on the hospital campus by His Highness the Duke of Kent. Not only will our students benefit from these glorious facilities but also trainee doctors, nurses and allied health professionals working at the Trust. It is a real symbol, and testament, to the relationship that has developed between our school and the hospital. Something, as our medical school develops, we would like to replicate in some way with our other partners.

We do, however, have an Achilles Heel: widening participation. We are desperate to be able to engage with this but because we are not HEFCE-funded we were excluded from bidding for the new medical school places announced by Jeremy Hunt. Given the obvious good we do – enhancing the NHS hospitals we work with and producing doctors, free of charge to the taxpayer, for those hospitals – why, then, can't the Secretary of State for Health find a novel way of funding a widening participation scheme through us? It would certainly be cost-effective and send such a positive signal that all avenues are being addressed to tackle our shortage of doctors.

# In 2018, drug company payments to NHS doctors remain hidden

The doctor, *Bad Science* author and policy expert **Ben Goldacre** explains why patients should know more about who funds their doctors



**I**t's common for doctors to take money from pharmaceutical companies. Occasionally, to be sure, this is lurid corruption, but that's rare. More common is the banal, day-to-day reality of doctors who have some kind of financial conflict of interest. Maybe they accept money from a drug company for travel to a conference. Maybe they're presenting the results of a trial about that company's drug. Maybe they take money to give educational lectures to local doctors about a particular medical condition, and they happen to have a pre-existing preference for that company's drug.

None of this is criminal. But it does all need to be openly declared, just like MPs declare their own conflicts. I'm a doctor, and I run the DataLab at the University of Oxford. This month we launched a new research paper, and accompanying website, describing what happened when we sent a Freedom of Information Act request to every NHS trust in the country, asking for all the conflict of interest data they hold. You can see the results for each individual trust at: [coi.theycareforyou.org](http://coi.theycareforyou.org). They're not pretty.

As with most problems, the issue is mostly chaos, rather than corruption. The General Medical Council (GMC) asks all doctors to declare their conflicts, but nobody specifies where, or how. NHS trusts are supposed to collect it for their own purposes, but none had a public disclosure register. Dozens sent nothing in response to our request. And nearly all the registers we did get were missing key

information. They simply disclosed that company "blank" gave £400 to doctor "blank". This reads very oddly, in 2018.

Why is disclosure being done so badly? It's a low priority. But these priorities are set by policy, and leadership. Many of us in medicine have advocated for a simple, central, mandatory database, managed by the GMC. Industry and the Royal Colleges have promoted voluntary disclosure instead but this has failed, as we said it would. The UK pharmaceutical industry body has a disclosure register where doctors are allowed to censor themselves: and literally half those payments are censored.

I know that many in pharma have been frustrated by this. Secrecy undermines public trust in the industry as well as the medical profession. And this is where the elder statespeople of my profession are most out of touch. Royal Colleges and Academies make sweeping statements about "building public trust" in medicine, and in doctors. But they always point to "better PR" as the solution. That might have been true in the 1980s. In the 21st century, we earn trust through transparency.

In particular, we get progress by making transparency banal. A financial conflict of interest is not a moral curse. It's a simple fact of life that needs to be disclosed, so that everyone can see it, and judge the impact for themselves. Conflicts are not always trivial, of course. As we discuss in our paper, there's good evidence to show that doctors, overall,



**The General Medical Council does not say where or how doctors must declare their conflicts of interest**

# NHS policy on disclosure is vague

**Goldacre's team collected data from hundreds of FOI request results into an index of NHS transparency**

## Trust ranking

RANK	NAME	SCORE	RESPONDED	REGISTER	DATA	PUBLIC	REUSABLE
=1	Airedale NHS Foundation Trust	80%	✓	✓	✓	✗	✓
=1	Cambridge University Hospitals NHS Foundation Trust	80%	✓	✓	✗	✓	✓
=1	Croydon Health Services NHS Trust	80%	✓	✓	✓	✗	✓
=1	Cumbria Partnership NHS Foundation Trust	80%	✓	✓	✓	✗	✓
=1	East and North Hertfordshire NHS Trust	80%	✓	✓	✓	✓	✗
=1	East of England Ambulance Service NHS Trust	80%	✓	✓	✓	✗	✓
=1	Northumberland, Tyne and Wear NHS Foundation Trust	80%	✓	✓	✓	✗	✓
=1	Nottinghamshire Healthcare NHS Foundation Trust	80%	✓	✓	✓	✓	✗

tend to hold favourable views about treatments where they have a financial conflict of interest. But that doesn't mean any single doctor is untrustworthy, and there are many good reasons to accept money from industry. It's simple: this must always be declared, so that colleagues, researchers, patients and policymakers can come to an informed and fair view about the impact of each doctor's financial conflict.

What happens elsewhere? In the United States, since the Sunshine Act came into force, everything is disclosed. The sky has not caved in, doctors simply got on with their lives. It has increased transparency. It has also created a single, simple disclosure system, and made it easy for doctors to be transparent, taking anxiety and uncertainty off the table. It has also facilitated important research. Last month a widely reported analysis found that the biggest prescribers of highly addictive opioids were also receiving large sums of money from the companies that market these drugs.

I hope there are not similar stories to be found in the UK. There may be uncomfortable isolated cases, but I hope we are less financially driven, as doctors, in the UK. And disclosure itself, of course, can help prevent shady practices. If any tiny number of doctors are tempted, then transparent disclosure

might help them to think twice.

But until that happens, we will put all the disclosures we can get into the public domain, on theycareforyou.org. And we will spotlight the gaps. Trusts with room to improve can use our site to find those Trusts doing disclosure well, and learn from them. Local people, patients, journalists, hospital staff, and local campaigners can also help drive up standards, by examining the data and bringing accountability.

What's next? I have two predictions. Firstly, NHS England has a new vague policy on disclosure. From long experience, I can promise you this won't be competently implemented, unless trusts are publicly held to account. Secondly, I truly believe that policymakers will act. Transparency is cheap. It's more important than ever before, because doctors are increasingly selling private services to local NHS commissioners. And it's something that the government can do to improve standards in the NHS without spending any money.

So I'm optimistic. My only sadness is this: we could have led the way. Instead, transparency will be imposed on my honourable profession, by politicians, because the current generation of medical leaders are living in the 1980s. So be it.



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**Judith Jolly, Liberal Democrat spokesperson for health, outlines the party's vision for a ring-fenced tax for health and social care**

# An honest approach to the biggest crisis of our time



**N**o one can be in any doubt that a crisis has been unfolding in our NHS and social care services in recent months. The reports of cancelled operations, patients stranded on trolleys, treatment standards reduced and ambulances queuing for hours outside A&E departments have been relentless. And while the headlines and the statistics are bad enough, the personal toll on the patients seeking treatment and the staff working in these conditions is more horrifying still.

Needless to say, this adds yet more weight to the already overwhelming case to give the NHS and social care more funding. Even Theresa May, who only a couple of months ago was claiming the NHS was “better prepared for the winter than ever before”, now appears to have conceded that her government can no longer bury their heads in the sand and pretend that services are not close to breaking point.

In the 2017 general election, the Liberal Democrats proposed increasing income tax by a penny in the pound. This would generate estimated additional revenue of £6bn, to be ring-fenced and spent only on health and social care.

It is well known that the NHS chief executive, Simon Stevens, called for the government to give the NHS in England at least £4bn more in 2018-19. Social care faces a funding gap of just over £2bn by 2020. So, the amount raised by this tax increase could put both these vital services back on a stable footing.

No political party takes the decision lightly to go into a general election telling voters that they want them to pay more tax. But I am proud that we were prepared to be honest with the public about the tough decisions needed to safeguard services in the longer term. The question of how we manage the growing pressure on our NHS and social care is arguably the biggest domestic crisis facing the country. To resolve it, we all need to chip in a little more.

While I don't underestimate the impact of asking anyone on a stretched household budget to pay more tax, this is a far fairer option for raising this much-needed money than the alternatives.

Thanks to increases in the income tax personal allowance fought for by the Liberal Democrats during the Coalition no one pays income tax on the first £11,500 they earn, so this will not hit the lowest earners. And of course, at the other end of the income scale, the more people earn the more they will pay.

Contrast this with the government's approach, to date, of trying to plaster over the cracks in social care by allowing local authorities to raise additional revenue through a “social care precept” – a ring-fenced council tax increase. There have been myriad problems with this. Council tax is known to be unprogressive, as it takes no account of ability to pay (with the exception of council tax benefit) and is based on extremely blunt and outdated measures of property values.

This system also risks exacerbating the



## To resolve this crisis, we all need to chip in a bit more



postcode lottery in services, with the least affluent areas (where, as a general rule, we would expect there to be the highest need) being able to raise the least through the precept. Thirdly, the amount which was raised by the precept to date has simply been far too little to bridge the funding gap.

Our health system will only work if we get social care right. We need to have a conversation about paying for care when we get old. It is not free, like the NHS. It is means-tested, and includes the value of your home. For many this comes as a huge surprise, especially if they live within the M25 where care home fees can be in excess of £1,000 a week.

During the coalition period Lib Dem ministers in the Department of Health proposed that there should be a cap on what we will be required to pay. The Conservative government has promised a green paper on this issue, first in the autumn of 2017, then after Christmas and now “in the summer”, but it is rumoured that it is proving to be “difficult” and it will be towards the end of the summer recess.

While there is certainly no magic wand to fix the growing need for NHS services, underfunding and staff shortages, we need to be prepared to look at bold solutions and to be honest with the public about the scale of

these challenges.

In the longer term, the Liberal Democrats want to see a move towards a single earmarked tax, bringing together the entire health and care budget, and based on a remodelled version of national insurance.

We have also urged the government to launch a cross-party commission to review the funding settlement for the NHS and social care in the longer term, working with patients, the public, and NHS and care staff.

To oversee the future sustainability of NHS and care budgets, we also strongly advocate the establishment of an Office of Budget Responsibility for Health, which would make recommendations to government about the funding required for a fixed period, just as the current OBR does for the economy and public finances. Their considerations should take account of the costs of meeting projected demand for services and of meeting any new policy commitments by the government.

We simply cannot get to this time next year and have our NHS battling through another winter crisis as bad as this one has been – or worse. If they are serious about protecting these vital services on which we all rely, policymakers from every party must be prepared to sit around a table and take some tough decisions. We wait with bated breath.

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BY THE NUMBERS

# The NHS workforce

**NHS England employs 1,198,238 people**

**10,796 senior managers**



Average pay is **£77,832**

**116,675 hospital doctors**



The average pay of a specialty doctor is **£60,670**  
The average pay of a first year foundation doctor is **£26,484**

**319,355 nurses**



Average pay is **£31,409**

**26,356 Midwives**



Average pay is **£33,087**

**21,695 members of ambulance staff**



Average pay is **£27,475**

**283,463 members of hospital support staff**



Average pay is **£18,874**

**66,085 members of infrastructure support staff for hotels, property & estates**



Average pay is **£17,982**



**33,423 full-time GPs**



Minimum pay: **£56,525**

Maximum pay: **£85,298**

## EU workers in the NHS

**61,934 EU citizens work in hospitals and the community: 5.22 per cent of the workforce**

**EU country nationals make up an estimated 95,000 – around 7 per cent – of the 1.3 million workers in England's adult social care sector**

## Vacancies

**In September 2017 there were 28,242 advertised full-time vacancies in NHS England**

**Nursing and midwifery had the most vacancies, at 40 per cent**

**Administration and clerical staff followed, at 21 per cent**



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