November 2019

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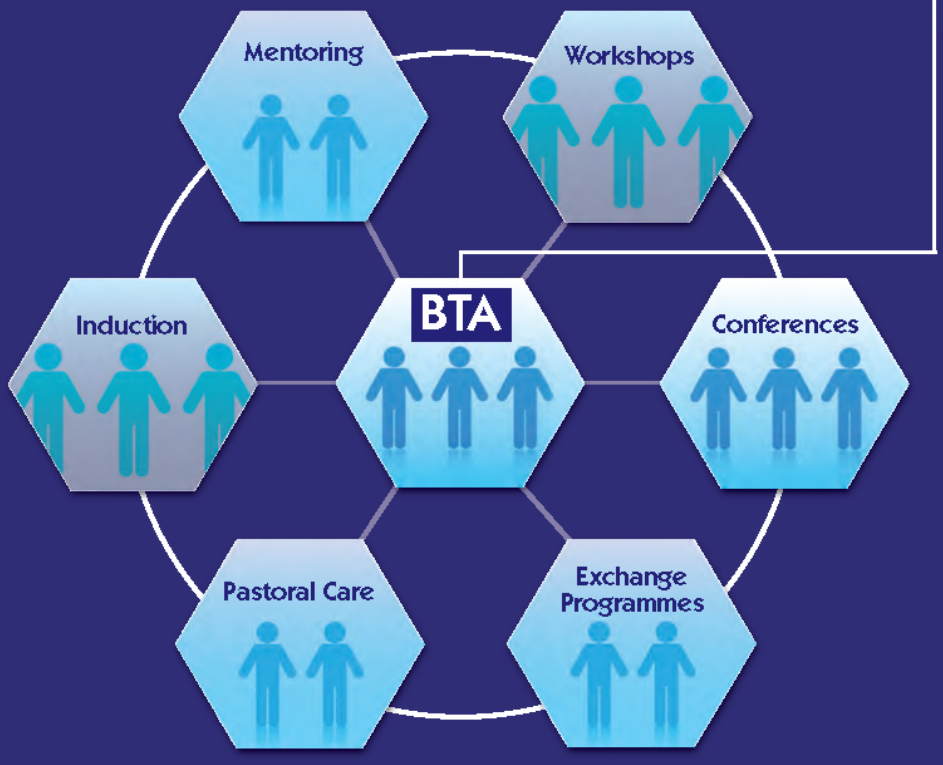
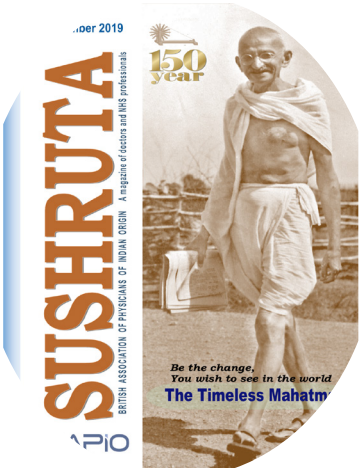


Contents



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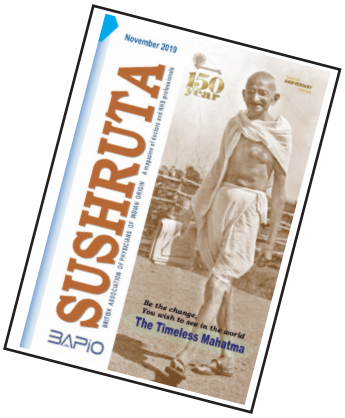

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From the Editor....

Universality of Social Health – Lessons from the Mahatma

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As you read the articles that I have had the pleasure to curate for this special edition of SUSHRUTA, published along with the #BAPIOAC19 conference in London this wet and frosty November, you will see glimmers of hope and aspirations of a broad-church of people that make up the health service. NHS professionals come from all over the world, bringing their cultures from distant shores that were once touched by the British Empire (now the Commonwealth) You will also witness the ambitious plans for future proofing what is arguably the best universal health system in the world. It is a time for 20/20 vision; we recognise not only the challenges that face the UK population and the NHS but we also envisage how the strengths of the diverse multi-skilled workforce come together in making the UK NHS star shine even brighter.

This is a time when we will hear of many promises from the various contenders for the UK parliamentary elections. As health professionals, we are sworn to absolute dedication to our patients, their care and safety. Most of us would shun, both in public and private life, involvement in any form of political discourse. As scientists we are trained to speak only when the evidence is compelling and that too providing a balanced objective view, yet medicine is an art and healthcare professionals are humanists. It is true that health professionals have not ignored the power of political discourse in changing the fate of their patients and their profession. In the 1500s medical practice in England was poorly regulated. Many 'physicians' were working with no formal training or knowledge. The leading physicians of the early 16th century wanted the power to grant licenses to those with actual qualifications and to restrict unqualified practitioners and those engaging in malpractice. A group of physicians led by Thomas Linacre petitioned King Henry VIII to establish a college of physicians in 1518. Even to this day, one of the key responsibilities of the Royal Colleges and professional organisations remains to petition the government, present compelling evidence and seek changes that will eventually improve the health of the nation.

Mohan Das Karamchand Gandhi, also known as Mahatma Gandhi may indeed be a controversial figure in his homeland, but is a global leader and is revered across the world for the principles with which he led his life and brought about enormous systemic changes for the improvement of the lives of ordinary people. In his 150th year of birth, we have an opportunity to reflect on how his belief in humanity, his principles of universal justice, self-sacrifice and leadership from the frontline are as relevant today, as they were when he undertook his 240 mile walk in 1939 across the salt flats of Gujarat in protest against the unfair and draconian salt tax imposed by the British government. His leadership qualities such as selfless service to humanity, self-sacrificial love, spirituality, integrity and humble living, were emulated by many transformational world leaders who drew inspiration from his life. He stood out for the essential principle that all men are equal and artificial distinctions based on race and colour were both unreasonable and immoral. He practiced what he preached and that can be such a powerful motivator for all. Unfortunately, in spite of the principles of universality that is in the founding principles of the NHS, the reality can be very different. There are significant differences in the health outcomes of segments of the population within boroughs, post codes and health sectors. The trajectory of the careers of healthcare professionals is no different; reflected in the differential attainment of students, the career progression of workers and 'glass ceilings' that present often insurmountable hurdles for ambitious individuals based on their gender, disability or racial characteristics. We will hear of initiatives that are being led by individuals and institutions to change this paradigm and close the achievement gap.

In this November national conference, we will be focussing on the multi-professional workforce, listening to the experience of extended roles from pharmacists, physician associates, advanced nursing, debate the funding models for the NHS, examine closely the educational and training pathways and learn from innovators from across the globe. Through our networks we will be reaching out to global health partnerships as we understand that improvement in UK population health cannot be divorced from the impact of health care related migration.

Organisations such as BAPIO, provide a voice to many who have often not been heard as they have toiled tirelessly in keeping this massive social movement, the very best 'Marigold Hotel' afloat and thriving. Such organisations hold a mirror up to organisations, provide a friendly challenge where there is a reluctance to open one's eyes and most importantly offer solutions in partnership, to move towards universality of access to the best healthcare for all patients and opportunities with a level playing field for each and every professional to reach their potential. This is the only way that a society can move forward and reach the World Health Organisations vision of Health for All.

Foreword by the President

Dr Ramesh Mehta OBE
President -BAPIO

To mark the 150th Birth Anniversary of Mahatma Gandhi, while we have Gandhi on our cover page; I recollect one of his core messages: "Those who behave like worms should not blame others for trampling upon them". As an organisation, we have tried to follow his advice and have always stood up for fairness and justice. By dedicating this issue of Sushruta to Gandhi, we pay tribute to a great soul, who not only guided the struggle for Independence of India but dedicated his life to promoting 'Truth & Non-violence." A unique and unparalleled human that many generations would note as 'Timeless Mahatma'.

BAPIO continues to raise issues and challenges the establishment while at the same time collaborating with it to find solutions. Our major concerns continues to be differential attainment of the BAME doctors and unfair complaint processes against them.

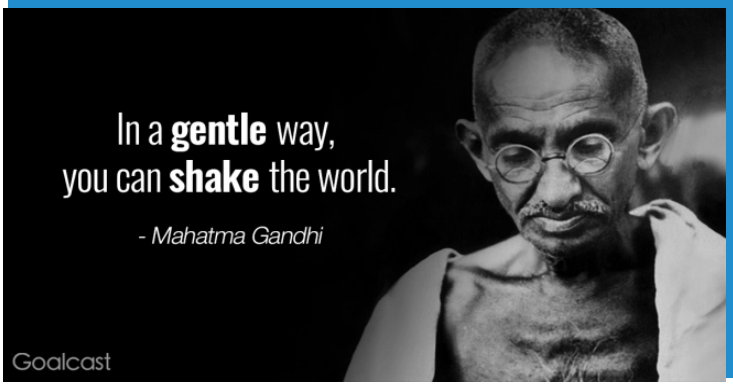
Hindrance in the career progression of BAME staff stops them from achieving their potential. Unhappy and demoralised staff is bad news for the patient care as well as huge loss of talent to the nation. Fortunately, thanks to the NHS Long Term Plan, there is consideration for supporting and looking after the happiness of staff. Appointment of chief people officer is a welcome step. We will be closely watching their work.

Unfair and unjust complaints against BAME staff is a major problem in all the trusts. The annual survey of Workforce Race Equality Standard (WRES) continues to reveal bullying, harassment and low morale of the BAME staff. As a solution BAPIO is developing partnership with hospital trusts to provide early conflict resolution services and cultural training to the staff to promote equality and inclusion.

I am pleased to commend this special edition of Sushruta that has number of interesting content and hope that the readers would find it informative.

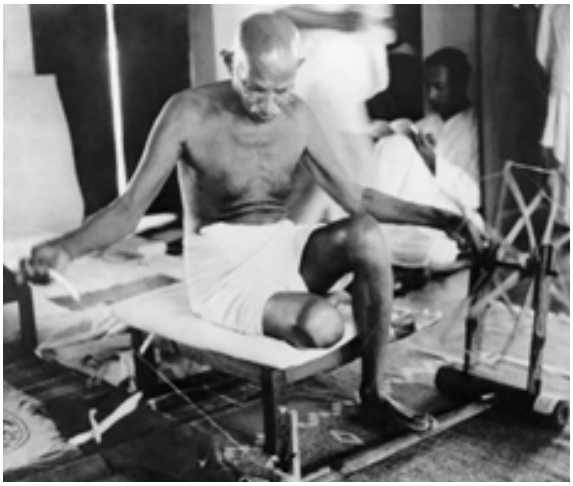
Finally, I would like to thank the Dr. Indranil Chakravorty the Editor and Dr Satheesh Mathew the Chair of the Organising committee of the Conference for their contribution. Thanks also to the Managing Editor Mr. Buddhdev Pandya MBE for developing this edition of Sushruta.

Ramesh Mehta



Timeless Mahatma

- Relevance to modern era



By Buddhdev Pandya MBE, Director of Policy BAPIO,
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This year the world celebrates 150th birth anniversary of Mahatma Gandhi. We ask how relevant are the lessons from the life and philosophy of this great man to our time of rapidly progressing, technology driven globalisation. Are we cognisant of the core 'Gandhian values' of self-lessness and non-violence?

We are beginning to see the signs of what Albert Einstein said of Mohandas Karamchand Gandhi (Mahatma Gandhi) that: "Generations to come, it may well be, will scarce believe that such a one as this ever in flesh and blood walked upon this earth".

Controversial it may be, but it does need to be noted that, while throughout the world people are celebrating his life, there are those in his own country, who still hold contrary views to his ideals of 'satyagraha' truth and 'ahimsa' non-violence and regard Gandhian philosophy as a sign of weakness. Notoriously, some even have gone further to honour his assassin, hailing Nathuram Godsey as a nationalist who did a service to India by ending Gandhi's life.[1]

In contrast, across many parts of the globe, communities celebrate his 150th anniversary. India's Prime Minister Narendra Modi said, "The nation expresses its gratitude to Gandhiji for his everlasting contribution to humanity. And, wrote on Twitter, "We pledge to continue working hard to realise his dreams and create a better planet."

Prime Minister of India Hon Narendra Modi paying tribute to Mahatma Gandhi at the Raj Ghat-Delhi

During the recent "Howdy, Modi" event in Houston US Congressman Steny Hoyer, the majority leader of the US House of Representatives said. "India, like America, is proud of its ancient traditions to secure a future according to Gandhi's teaching and Nehru's vision of India as a secular democracy where respect for pluralism and human rights safeguard every individual."

Gandhiji stood for fairness and universal equality. He fought for the upliftment of the downtrodden masses in India. His vision of equality is still relevant to the Indian diaspora comprised of about 1.4 million people in the United Kingdom.

The British Indian medical fraternity for the first time in 2006, participated in a peaceful demonstration in White Hall. The strength and inspiration was derived from the values of Gandhiji was echoed by the fraternity that we have to stand for our rights and demand to be treated fairly and justly in the NHS.

The decade that followed reflected British Association of Physicians of Indian Origin (BAPIO) as a body that took political action, became an institution; in a small way a symbol of hope among the national voluntary bodies representing the IMGs. Perhaps, taking a leaf from the values of the Mahatma, creating a legacy for the founders of the organisation.

Gandhiji through his own life demonstrated an exemplary self-less leadership style whose personal conviction and dedication to his fellow man were unparalleled. An ideal case study for aspiring leaders in its true meaning. Implementing high standards in ideology and ethics that are matched in conduct for excellence reflected in his personal life- is the Gandhian message.

BAPIO and supporting Doctors demonstrating before the Department of Health 2006

https://www.bapio.co.uk/wp-content/uploads/2016/02/Harmony-June-2006.pdf

A brilliant campaigner with strategic mind focused on delivery and outcomes, was his mark that we in the medical profession must try to emulate.
Most relevant of the Gandhian principles is one of embracing diversity and promoting cohesion. For the modern medical fraternity, individual leadership and collective forums should aim to become a source of empowerment and an influencer of change of what is often a hostile environment.

We have to be the change that we want to see in the NHS, as we are a part of the public health service. ❑

BAPIO delegates submitting petition to the Department of Health

http://news.bbc.co.uk/1/hi/health/4928954.stm

The Long-Term NHS Plan:
Putting People First

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New guidance from NHS Improvement will help to focus minds on establishing an NHS that regards people management procedures which impact staff wellbeing with the same urgency as it regards patient safety. I outline a culture which values and promotes Fairness, Accountability, Compassion and Excellence ('FACE'). I also offer some advice for doctors in difficulties.

The Long-Term NHS Plan states (2019, p. 86) 'The NHS draws on a remarkably rich diversity of people to provide care to our patients. But we fall short in valuing their contributions and ensuring fair treatment and respect'. Mental distress, up to the point of suicide, has been highlighted as a major concern for doctors in their workplace, and this may be particularly evident when doctors face investigations and disciplinary hearings.[1-3]

BME staff appear to be especially vulnerable to unfair treatment. The case of an award-winning nurse, Amin Abdullah, who burned himself to death outside Kensington Palace following an unfair dismissal in 2016, has led to key Recommendations from an NHS Improvement (NHSI) Advisory Group. The Recommendations call for alternatives other than dismissal and suspension to be fully explored, independent expert input to disciplinary processes, the principle of plurality to be inherent in key decision making, and accountability for those who treated staff unfairly. The Recommendations, together with a YouTube video of Amin Abdullah's story, A Nurse's Tragic Journey, are available at www.abetternhs.com.

How can we create a better NHS culture to prevent such tragedies in the future? My views can be summarised in an acronym, FACE, which derives from four basic principles –

- Having Fairness as a key standard for how staff are treated, with the CQC introducing 'Fairness' as a new inspection domain.
- Ensuring that there is Accountability for staff who make decisions which adversely affect staff wellbeing.
- Showing Compassion to staff in ways which show that their wellbeing is held to be as critically important as that of patients.
- Promoting Excellence, underpinned by effective learning of lessons when mistakes are made.

There is a general concern about how NHS staff are treated when being investigated or disciplined.[4,5] The Care Quality Commission needs to ensure that the NHSI Recommendations are implemented, with sanctions if they are not properly implemented. We also need to ensure both excellence and accountability for healthcare staff in management roles, something that health secretaries have prioritised.[6,7] Specific further steps include –

1. NHS England should introduce a Redeployment Scheme to enable staff working in toxic environments, or who were unfairly suspended or dismissed, to work in another environment to help them return to clinical practice in a fulfilling role. A similar scheme has been successfully run by NHS Wales for a number of years.
2. There should be awards to recognize the bravery of staff who become whistleblowers and speak out at great personal cost when they see wrongdoing and unfairness in the workplace.
3. Other areas where staff may be unfairly treated, such as selection, promotion/merit awards, change in working conditions, bullying, etc, need to be covered in future NHSI Recommendations.
4. It is sometimes healthcare

professionals in management roles who contribute to a culture of unfairness.[8] Professional bodies, such as the Royal Colleges and the BMA, and regulatory bodies such as the GMC, should develop relevant guidance for their members; guidance proposed for psychologists may be helpful.[9]

5. Relevant aspects of NHS management should be part of healthcare professional training, and induction programmes for NHS employees.
6. Trust Executive Boards should sanction every case of dismissal or suspension of a healthcare professional.
7. Healthcare professional bodies, such as the Royal Colleges, should re-introduce forms of accreditation for services,[10] including management roles assumed by members.
8. Many Trusts have 'Equality & Diversity' officers, and their role should be expanded to become 'Equality, Diversity & Fairness' officers.
9. The Healthcare Safety Investigation Branch exists to learn lessons from mistakes in patient care. An equivalent body, a Healthcare Staff Wellbeing Investigation Branch, should be set up to learn lessons from mistakes in people management.
10. Before nurse Amin Abdullah's life was sacrificed, there were repeated failures to listen to concerns and learn lessons. The Department of Health, NHSI, the CQC and NHS Employers should each reflect on why lessons were not learned, and publish their reflections.

It is now clear that staff wellbeing and morale are closely linked to quality of patient care.[11,12] For healthcare staff in difficulties, my key advice is –

- Look after your physical and mental wellbeing, and that of your family
- Always seek external, expert advice
- Stay calm at times of stress; do not act on impulse; avoid scoring 'own-goals'. Remember the three P's – Be Patient, stay Positive, and show Perseverance.

Further tips and also my wellbeing booklet can be found on my website, www.clinicalexcellenceuk.com.

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The promise of a new NHS under the Long term plan 2020-2030 – A medical student's perspective

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The UK is in a state of change, from the political scene, to the climate crisis, to the technological revolution. These factors will not only change the world that we live in, but also our healthcare system. We are on the cusp of a new era for the NHS, and as a medical student, this novel NHS will be the one that I will work in. Naturally, this makes me wonder what this new NHS will look like, and what these changes will mean for medical students.

Earlier this year the NHS published their long-term plan, which lays out the key ambitions for the service over the next ten years. The demographics of the UK is changing, and this plan aims to help the NHS evolve into one that is suited for this growing and ageing population. The proposal sets out several funding targets and ambitions, but as a future doctor, the aims that stand out most to me are the clinical ones. The proposal focusses heavily on practicing preventative medicine, with the aim to reduce the burden of hospital admissions through implementation of public health initiatives and improving social and community care.

One major public health initiative is to reduce the number of smokers. Although smoking rates have decreased significantly over the past few decades, around 6.1 million people in England still smoke, and smoking accounts for more years of life lost than any other modifiable risk factor[1]. Furthermore, smoking is linked to around half a million hospital admissions each year, and smokers see their GP over a third more often than non-smokers[2]. In order to reduce this burden and improve public heath, the NHS plans to implement a new model where all smokers admitted to hospital will be offered NHS-funded smoking cessation services. A similar model was successful in Canada and was shown to improve long-term quit rates by 11%[3]. This is a great idea, and as a student in my first year of clinical training, now is the best time to learn new protocols, whilst I navigate new challenges such as how to take a history and deliver care. Learning about how the long-term plan will affect clinical practice is crucial for current medical students, as we are the ones who will be carrying out the new changes.

Another aim in the long-term plan is to improve primary and community health services. Having just returned from my General Practice clinical attachment, I have witnessed first-hand the importance of primary care in tackling long-term conditions and treating patients in a holistic manner. Improving communication between primary, community and hospital care instead of considering each encounter with a health service as an isolated event will be important in doing this. In my placement, I witnessed the workings of a truly multidisciplinary team, including GPs, nurses, pharmacists, social prescribers, psychologists, physiotherapists and managers. This team connected with the community and catered to their specific needs. Perhaps the future of the NHS will be a place in which more medical students are encouraged to become GPs, as the focus of medicine shifts into the community.

Currently, healthcare is being transformed at warp speed due to advances in several technological fields, such as genetic engineering, regenerative medicine, artificial intelligence and nanotechnology, to name a few. This era marks the beginning of a Fourth Industrial Revolution which has the potential to fundamentally change the way we receive and practice healthcare. One might assume that the development of advanced, specialised den and

high-tech medicine will counteract the NHS's planned shift in focus towards community-based care. However, I believe that certain technologies will actually aid this sector immensely.

For example, medical devices, implants and even smartphones can collect data such as blood pressure and glucose level that can be analysed and communicated in real time to healthcare professionals. These can be used as aids in clinical decision-making and management of patients. The use of telemedicine has the potential to revolutionise the way healthcare services are delivered. This could reduce the bur of waiting and travelling to hospitals, especially for patients with chronic pain, poor mobility or those living in isolated areas.

For the ageing population, virtual home assistance will connect patients to healthcare professionals and family members. This not only will aid in medication adherence and care coordination but also help to reduce loneliness. The long-term plan also acknowledges the impact that technological advancements will have on the NHS, on everything from diagnosing diseases to delivering care via artificial intelligence. My generation of medical students have grown up in an age where technological literacy is a life-skill. This makes us the ideal candidates to take the NHS forward in this technological era.

Although this future of the NHS seems very exciting, there are still several issues which need to be addressed in the coming years. As a second generation Indian, I am concerned about how factors other than my dedication, hard work and academic ability (i.e. the colour of my skin) may affect my education and future career as a doctor. The culture of blame in the NHS has risen exponentially, and does little to advance patient safety, instead it ostracises a few and creates a fearful work environment.

Teamwork is vital in the NHS, with everything from training to treatment relying on the seamless cohesion of professionals. However, a report commissioned this year by the GMC showed that Black and Asian minority ethnic (BAME) doctors are often treated as outsiders by colleagues and are consequently not supported. The issue is seen in medical training too, as UK born BAME students do worse in exams compared to white students. In 2017, the pass rate in postgraduate exams was 75% among white students, and 63% among UK BME students[4]. It seems clear that the key to addressing issues begin in a supportive learning environment that fosters diverse social networks, improves trainee-trainer relationships and encourages open conversations about race as important first steps. Race and cultural isolationism also adversely affects outcomes in patients accessing healthcare services. Organisations such as BAPIO are leading the conversation on discrimination, and this makes me hopeful that the NHS I will work in will be making real steps towards racial equality.

Another issue that the future doctors will have to tackle is the global climate crisis and how it relates to healthcare. The World Health Organisation states climate change as the greatest threat to global health in the 21st century, and it is widely accepted that climate change will have significant consequences for healthcare requirements and provision. I believe that for medical students, awareness and education are essential. Currently, environmental medicine is not part of the core medical curriculum, which is why my peers have set up the Oxford Healthcare and Environment Society.

We aim to discuss with the faculty how issues surrounding the climate crisis and health could be incorporated into the syllabus. Since the NHS is the greatest public sector contributor in England to climate change, emitting 20 million tonnes of CO^2 per year, this is a crucial issue[5].

So, what does the future of the NHS look like? To me, it is one that is technologically savvy, sustainable, just and specialised to serve a changing population. As one of the doctors of tomorrow, the onus is on me to deliver such a service. There are many challenges left to face, but I am excited to enter a world-renowned healthcare service and be a part of its future. It certainly is a brave new world. ❑

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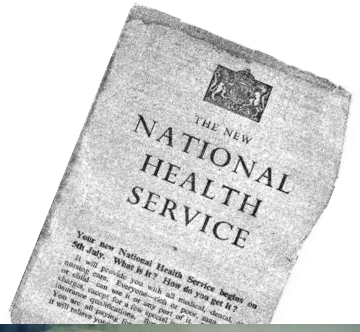

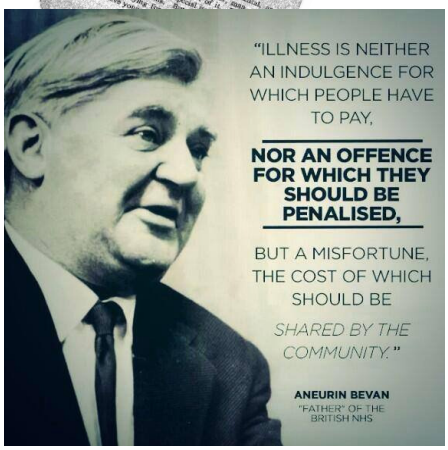

Challenging the NHS long term plan

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The NHS long-term plan, announced early this year with £20.5bn of funding, was seen as atonement by The Rt Hon Theresa May MP for the health service being starved of funding for the past nine years.

But the extra funding will barely make up for nine years of austerity that have crippled the NHS and social care and undermined public health. The Health Foundation think-tank rightly warned that ministers must spend an extra £8bn a year on health, on top of the £20.5bn increase, or the plan will fail.

Aside from the funding issues, delivering the plan depends on political choices outside the control of the NHS, particularly on Brexit, social care, and wider social policy. A no-deal Brexit could stall investment in the NHS and worsen staffing shortages. Continuing to duck decisions on social care funding will pile even more pressure on the NHS. And continued cuts to public health and social services will undermine the plan's ambitions to improve health and reduce inequalities.

The five year forward view – the blueprint that preceded the long-term plan – was both ambitious and humble as it recognised that the sustainability of the NHS and an improvement in health outcomes demanded action and participation beyond the health service. The long-term plan focuses exclusively on the NHS. Despite its objectives on prevention and sustainability, it prescribes only solutions amenable to NHS control. Any reform that fails to account for such crucial issues as public health and social care cannot be seen as a credible proposal, let alone be called a "long-term plan".

A further five issues could limit the plan's potential to deliver on its aims.

1. Inspiring leadership and participation: the plan does not abandon the health service's culture of targets and tick boxes. Although it includes rhetoric about patient and public involvement in health, there are few practical solutions.
2. Narrowed ambition: there are three gaps to plug – health outcomes, finances and care quality – but only one of those sits solidly within the ambit of the NHS. Health outcomes and financial sustainability rely on sectors beyond the NHS: in social care, in wider public services, among the public themselves. The long-term plan acknowledges this but doesn't seek to encourage or incentivise the NHS to build those alliances.
3. Facing upwards not outwards: accountability is upwards to regional and national structures, not outwards to the population served. Devolution can change that. NHS Scotland is still recognisably the health service, but its political accountability is more direct.
4. Increasing demand: as a society we are all living longer; it is projected that the population over 75 in the UK will double in the next 30 years, and by 2040 nearly one in four people will be aged 65 or over. Deep-seated health inequalities continue to exist across society and different regions in the UK, as well as an epidemic of largely preventable long-term disease and ill-health. This has created a challenging environment for patients and doctors working in an already pressurised service. Strains such as these are causing patients to wait longer.
5. Workforce crisis: the most concerning omission is the absence of a comprehensive plan to address the severe problem of the NHS staffing crisis. Such a strategy should have been incorporated; instead the Interim NHS People Plan was published separately this August.

The problems facing the health service are likely to be compounded by staffing shortages in social care, which will almost certainly be exacerbated by Brexit. Workforce shortages in health and social care are at an all-time high.

With the NHS at breaking point, if the government doesn't get to grips with this workforce crisis, the health service will struggle to attract and retain highly trained staff, and patient care will continue to suffer as a result.

In many ways, the workforce crisis is worse than a financial calamity; the only thing keeping the health service going is the goodwill and dedication of its staff, but believe me, that goodwill is dangerously close to running dry. When it does, we will have not have the NHS of which we are so proud.

The NHS is like a black hole to ministers – they know it's there, but act as though it's way beyond us in outer space and so they don't have to find a solution.

They would rather have a shrinking NHS, workforce and funding crises. The long-term plan is a half-baked solution to these problems and, like Andrew Lansley's reforms, will end in tears. ❑

RCPCH responds to NHS Longterm Plan Goals – The Paediatrics 2040 vision

Jo Revill, CEO, The Royal College of Paediatrics and Child Health

It gives me enormous pleasure to be able to attend and contribute to BAPIO's annual conference, a time when doctors from the UK and abroad can come together to share ideas, learning and experience.

Our College enjoys a membership of more than 19,000 paediatricians, with more than 20% working outside the UK and the EU. Our global health work continues to grow: we work with local societies and volunteers in 18 countries to carry out a very busy programme of examinations and training. The College also has a humanitarian programme of work in low-income countries with UNICEF and others, working with volunteers in Rwanda, Sierra Leone and Myanmar, helping to strength their systems to improve care for the youngest.

Colleges must also ensure that they can represent the breadth of their membership properly. We have set up an independent group co-chaired by our international Officer, Dr Bhanu Williams, to look at how we maximise opportunities for all of paediatrics, to ensure that we remain a diverse body and benefit from all the skills and experience contained in our active and passionate membership body.

Over the past year, we have worked very hard to support the development and now implementation of NHS England's Long Term Plan, its ambitious blueprint setting out plans for improvements of the service over the next decade. It was important for us that the services for children and young people received considerable attention within this, setting out clear pathways for more integrated and personalised services. There is now a Transformation Board set up to implement the delivery of this plan, on which our President, Professor Russell Viner, is vice- chair.

The Long Term Plan work is our opportunity to transform the way child health is delivered in the country, to ensure that there is proper integration between services, with the resources they need to do the job properly. Importantly, there is a big focus on meeting the mental health needs of so many young people.

As a College, we also work with governments and bodies in Scotland, Wales and Northern Ireland as health is a devolved issue for each nation. We also publish The State of Child Health annually, a document recording how progress is being made in a range of areas in each nation where we need to see better outcomes.

The College has recently started a new scheme to attract paediatricians to become RCPCH Ambassadors across the country, and they will help us to advocate for the improvement of local services in ways that benefit children and ensure that local commissioners have someone to talk to about the local child health workforce.

We know that for our members, it's important that the College can help enable them to use their expertise, communications skills and knowledge in order to deliver better outcomes for young people.

Last year, Professor Viner launched Paediatrics 2040, a project that will look 20 years ahead to understand the challenges paediatricians will face over the coming decades and identify the best ways that a truly 21-st century College can support its members and fulfil its mission to promote child and adolescent health.

For many of the attendees at the conference (#BAPIOAC19), prevention of ill health is high on the agenda. Primary prevention that begins before birth is crucial to the success of any NHS plan.

Improvements in service provision will only provide a sticking plaster if the circumstances in which the country's poorest children grow up do not improve.

Prevention is an integral part of the solution to many of the problems that children face, from increasing mortality rates, to high prevalence of obesity, to widening social and health inequalities.

To learn more about our priorities in this area, please go to: *https://www.rcpch.ac.uk/resources/rcpch-prevention-vision-child-health*

The invaluable contribution of overseas doctors to the NHS

Derek Bell OBE
President of the Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh represents thousands of Fellows and Members across the world, many of whom have international roots. That is something the College is immensely proud of, and we take every opportunity we can to celebrate that diversity. Indeed, the College has deep international roots, supporting international doctors through the Medical Training Initiative (MTI) and the International Medical Training Fellowship Programme (IMTF). We have an international Vice-President, who engages with our international Fellows and Members, and feeds their views back to the very heart of College decision making. The College does all it can to promote international doctors and their importance to the NHS in the UK – and this goes right to the heart of our policy work on the NHS workforce.

As you will be aware, recruitment and retention of staff is one of the most important roles of any health service. Yet in the UK, there are a range of barriers and challenges to fulling this vital task. Factors such as rota gaps, early retirement, medical student dropout rates, pension changes, poor working environment and Brexit have all impacted NHS recruitment and retention in one way or another.

Worryingly, nearly half (48%) of medical consultants in the UK are expected to reach 60 years of age within the next decade. And 40% of medical consultants will reach the intended retirement age of 62 years and 3 months, within the next 10 years. That's according to Focus on Physicians 2018, the annual census survey conducted by the Royal College of Physicians of Edinburgh and its sister Colleges in London and Glasgow. And according to the GMC National Training Surveys for 2019, one in four junior doctors is worried about burnout due to a heavy workload. This points major challenges at both the early and later stages of a doctor's career.

The Royal College of Physicians of Edinburgh supports the increase in medical school places to meet future service requirements, however this will take over a decade to impact on numbers of doctors and current staffing levels still need to be addressed. The College is keen to support initiatives aimed at recruiting international and European medical staff – and in Scotland, we have been working with the Scottish Academy of Medical Royal Colleges to build the network of international doctors.

Happy medical team at a NHS Hospital

Many medical trainees who come to this country to work do so under fixed term programmes, to further develop their clinical skills and contribute directly to patient care in the NHS. The fact that the NHS and our patients benefit from the skills of international doctors, while they are in the UK, makes it a truly win-win situation.

Those doctors often return home with greater skills and experience. It is estimated that there are over 50,000 doctors of Indian origin serving the NHS, whose contribution has had – and will continue to have a significantly positive impact on the health of people in the UK.

The NHS has always been part of a global health economy, and I am proud that this College, along with other Medical Royal Colleges, is part of a programme - the International Medical Training Fellowship Programme (IMTF) - that is benefitting individual doctors, the NHS and countries around the world, to tackle health challenges and share expertise. With the number of unfilled posts in the NHS predicted by the Nuffield Trust to rise to 250,000 by 2030, programmes that are mutually beneficial like this should be expanded. Similarly, the current NHS spend on locum and agency staff is in excess of £300m in Scotland and £1bn in England, and this money could be used more effectively to employ more permanent staff – including those from overseas. At a time when we have many gaps in clinical service rotas we must move from a capped system for the number of trainee doctors at least in the short term.

As the NHS continues to experience rising demand, it is absolutely vital that we continue to recruit and retain a world class workforce to deliver the best possible patient care – and international doctors will continue to play an important role in this. Effective workforce plans and policies must be in place to ensure that overseas doctors can continue to work in the UK.

But we must also make sure that our workforce is valued. All NHS medical staff – including international medical consultants – should feel valued no matter what their background, level of experience, or specialty. I hope that international doctors – including those of Indian origin – will continue to have the support they require in our NHS. ❑

Incivility in Healthcare

– A systems approach

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The link between civility, workplace safety and patient care is not a new concept. The 2004 Institute of Medicine report, emphasised the importance of the work environment in which healthcare professionals provide care.[1] Workplace incivility that is expressed as bullying behaviour was reported by at least 1 in 5 respondents in the NHS Staff survey in 2018.[2] Almost half of these go unreported and that number seems to be falling.

Workplace bullying (also referred to as lateral or horizontal violence) is repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms;

- Verbal abuse
- Threatening, intimidating or humiliating behaviours (including nonverbal)
- Work interference – sabotage – which prevents work from getting done

There are five recognised categories of workplace incivility

- Threat to professional status (public humiliation)
- Threat to personal standing (name calling, insults, teasing)
- Isolation (withholding information)
- Overwork (impossible deadlines)
- Destabilization (failing to give credit where credit is due)

The results of the Race at Work 2018: The Scorecard Report[3] published one year after The McGregor-Smith Review: Race in the workplace found that 1:4 British black, Asian and minority ethnic (BAME) employees were reporting being exposed to incivility in the workplace across all sectors. The results highlighted that BAME people in the workplace were ambitious, but there was a lack of opportunity and a strong desire for opportunities that was not being fulfilled. This was a waste of talent, energy, enthusiasm and expertise. The UK workplace is still not considered a conducive environment for talking about race, hence propagating the culture of under-reporting.

Workplace incivility can have devastating consequences for the individual, team morale and result in poor performance for the victim and the surrounding team. The adverse impact on patient care is significant. By means of specific impacts resulting from bullying and harassment to staff health, sickness absence costs to the employer, employee turnover, diminished productivity, sickness presenteeism, compensation, litigation and industrial relations costs; conservative estimate of the cost to the taxpayer was £2.281 billion per annum in 2016-17.[4]

The causes of such incivility are manifold and include personal characteristics of the target or perpetrator but more often than not, there are institutional/ environmental factors that propagate such behaviours[5,6] Particularly relevant to the healthcare sector are; "Boiler room" environments- typically in emergency departments, operating theatres and labour rooms; competitive, hard-driving cultural image of leaders as "movers and shakers' tend to under value employees opinions while driving 'targets', inspiring terror by abusing/ ridiculing employees—a misguided but common notion of how to motivate trainees, disorganized, exploitive work environments. In addition where involvement is not facilitated, morale is low, teamwork is not encouraged, supervision is poor, worker role-conflict and strain; Although often difficult to quantify, most organisations where incivility is rife recognise 'cultures' that accept bullying as an aspect of doing business and authoritarian rather than participatory leadership styles as important factors.

How then should one tackle this incivil behaviour in healthcare? There is an increasing suite of policies and guidance for employers (line managers)[7] and confidential support offered to targets. Strict policies are implemented when in a small proportion of cases bullying is reported by human resource processes. Most NHS Chief Executives would happily rally around a zero tolerance policy. However, there seems to be little improvement noted in recent surveys. There is a missing link and the answer perhaps is in organisational proactiveness to change a 'culture of bullying at a system level'.

In a recent initiative undertaken jointly by Health Education England (HEE) and NHS Improvement, a

series of confidential interviews with affected staff in a few pilot sites in England, found that a stressful, disorganised working environment, lack of mutual respect born of segregated working practices, fractious interactions, power imbalance, lack of social interactions or knowledge of each other's cultural differences, unmanageable work pressures due to rota gaps, culture of blame and fear of retaliation were some of the common themes.

The intervention included a facilitated Change Laboratory® methodology[8] for developing work practices by the practitioners. It facilitated both intensive, deep transformations and continuous incremental improvement.

The team organised on the shop-floor, a room or space for analysing disturbances and for constructing new models for the work practice. The team worked closely with the participants to develop a charter of excellence and a journey of defined 'smart actions' to implement change. The change was led by internal champions who were entrusted to model excellent behaviours and call out deviations.
More importantly, the members identified simple measures such as being referred to by first names, daily introduction to the team, multi-professional shared responsibility, regular shared learning events, multi-professional handovers, daily safety huddles and reform of archaic working rotas to effect improvement.

Interestingly, none of the members identified individual perpetrators as the sole cause of the incivil working environment. For such a scheme to be successful a strong commitment was necessary from the senior leadership.

It is important to acknowledge that it is more likely that organisational culture is responsible for supporting and propagating workforce incivility and therefore to be successful, institutions must invest in change from within. For success, one requires a true commitment from leaders and a safe space to develop charter for change.

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Historical look at Indian Healthcare Professionals in the NHS

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Doctors and nurses from the Indian subcontinent have been working in the UK healthcare sector for over a 100 years. Initially only open to Europeans, Indians were allowed to enter the Indian Medical Service (IMS) in 1855, although the requisite was that they had to sit exams based in London and had to be registered with the General Medical Council (GMC). At the time there were many schools training Indian doctors, but only as licentiates. In relation to medical education, through pressure applied by the IMS, indigenous courses for the training of Indian doctors were abolished and several medical colleges, modelled along western pedagogic styles, were established. The staff of all these colleges were appointed from the IMS and their methods of instruction were virtually indistinguishable from those practised in England and Scotland. Indian degrees were recognised in 1892 by the GMC and this recognition persisted until 1975, with a short interlude in the mid-1930s when there was a dispute between the GMC and the Government of India about the quality of Indian medical education. [1]

However, the development of medical practice in India did not follow the pattern that should integrate indigenous practice with 'western medicine' and they should not be over reliant on medically trained professionals, relying instead on medical assistants and health workers who did not have to undertake a full-fledged medical training. The emigration of Indian doctors, the failure to produce a coherent medical policy, and the absence of public-health medicine and health facilities in rural areas meant that Indian degrees were quite suitable for working in England, but probably totally irrelevant for working to the benefit of the vast majority of the Indian population. [1]

It is estimated that by 1945 there were 'no less' than 1000 Asian doctors throughout Britain, 200 of them in London alone and most of them working in primary care. In 1960, Enoch Powell, Health Secretary took the lead to change the immigration policy in order to meet the workforce demands of the NHS. Improved immigration policy helped, amongst others, Indian doctors and nurses to study further and progress to more secure jobs. [2]

In the 60s and 70s, many internationally recruited healthcare workers faced open racism and discrimination often leading to repetitive failures in examinations and stunted career progression. A TV comedy series 'The Indian Doctor' portrayed the challenges faced by Indian healthcare professionals working in remote communities [3].

It is also true that many doctors were also probably influenced by the 'Gandhian philosophy' of service to the benefit of humanity without personal rewards. This is perhaps why many doctors also ended up in deprived areas and became involved in local politics. At the end of the 1970s, the Royal Commission on the NHS[3] estimated that between 18,000–20,000 registered doctors in the UK were born outside the UK, with half of these being from India or Pakistan. A 2005 report found that in 2003, 29% of NHS doctors were foreign-born and that 44% of nurses recruited to the NHS after 1999, were born outside the UK.

As the gaps existed in unpopular areas or 'hard to fill' specialities, they were allowed to work in inner cities or remote areas as well as district general hospitals. There was already an official acknowledgement of the roles that these overseas doctors were playing. In a debate in the House of Lords in 1961, Lord Cohen of Birkenhead commented on the fact that:

'The Health Service would have collapsed if it had not been for the enormous influx from junior doctors from such countries as India and Pakistan.'[4] Lord Taylor of Harlow in the same debate said:

'They are here to provide pairs of hands in the rottenest, worst hospitals in the country because there is nobody else to do it.'

Although it is useful to understand immigration from the point of view of the state, it is also important to acknowledge that, much like the late 19th and early 20th century, because of the links that have already been described, many overseas qualified doctors had a personal desire to come to England to improve their clinical training, to work in the great institution of the NHS, and to pick up skills that they would then take home. Many of course chose to immigrate permanently, but the most common reason for coming was to obtain skills and then go back. Even to this day the premium of British experience continues to play well particularly in the private medical sector in many Commonwealth countries. But what was clear from the outset was that both the jobs and the experience available to this influx of immigrant doctors were going to be severely restricted. Over half of migrant

doctors were disappointed with their experience of working and studying in this country.[5] So they ended up being tied to the UK and the NHS, because returning without fulfilling their aspirations was not an option.

The experience of the International Medical Graduates (IMGs) and nurses included themes such as, the devaluation, self-blame, discrimination/lack of equal opportunity, invisibility, experiencing fear and tolerated such behaviour for fear of being thrown out with their families. As the primary motivation was to provide an excellent service to their patients rather than seek recognition or fame, the contribution of many doctors and nurses of Indian origin were forgotten and lost in the NHS. Frustrations grew and interviews revealed some common themes for dissatisfaction such as; feeling devalued and deskilled and perceptions of racial discrimination, not feeling personally or professionally valued and unmet expectations. [6,7]

Migrant doctors were more likely to become GPs against their inclination, and more likely to be practising in a speciality that was not their first choice. They were also more likely to feel that they had progressed more slowly in terms of postgraduate training and experience. These included the policy of rotating posts at teaching hospitals. This may also apply to vocational training schemes. [5]
Working at a teaching hospital helped in the fostering of vital informal networks which could greatly influence a young doctor's entry into the key areas of many specialties. Having trained outside of Britain migrant doctors were more likely not to have cultivated a reputation in a British teaching hospital from which rotational opportunities tended to arise.
Despite such negative experiences participants indicated that the experiences gained whilst working in the NHS were useful. IMGs who wanted to see the NHS and the general working environment improve, took active parts in meetings of British Medical Council (BMA) and the GMC. A need was felt to have an Indian associations of doctors in different regions of UK, hence organisations like Overseas Doctors Association (ODA), Indian Medical Association (IMA-UK) were conceived. In parallel other organisations sprung up from Hindu International Medical Mission to Sewa International, BAPIO to Global Association of Physicians of Indian Origin (GAPIO), as a way to represent the Indian doctors globally.

NHS is celebrated by the politicians and public alike as a great British institution, yet from its inception it has been crafted and nurtured by the contribution of a significant number of international medical and nursing graduates. Incorporating narratives from migrant healthcare workers into general histories of the NHS would give us a more holistic understanding of the past and a different perspective on the present. It is in this sense that one would argue for a need to broaden understanding of who the 'architects' of the NHS were. NHS is an evolving organization brought into existence by the actions of thousands of people, many of whom were migrants, rather than as a monolithic structure established by politicians and civil servants in the immediate aftermath of World War II. Approaching the history of the NHS from such an angle could lead to a better understanding of what impact migration might have had on the development of healthcare in Britain. Is the daily practice of psychiatry in Britain influenced by the fact that the specialty employed hundreds of practitioners trained in the Indian subcontinent? To what extent has engagement with ethnic minority patients been shaped by the presence of migrants in the NHS workforce? Our inability to provide detailed answers to such questions is a major gap in our understanding of how the NHS evolved. [1,9]

As NHS enters its seventh decade and a new 10-year strategy is revealed, there needs to be a greater understanding and acknowledgement of the huge contribution of international medical and nursing workforce in the shaping of the future of this country. In 2018, as NHS turned 70, the Royal College of General Practitioners (RCGP) exhibition has attempted to highlight the contribution of IMGs (many from the Indian subcontinent) as architects and lifeblood of NHS and primary care provision in the UK.

We now understand that healthcare migration has mutual benefit to both countries of origin as well as adopted lands. This is evident in USA, Canada, Africa, Australia and New Zealand through further emigration/ immigration. Medical immigration also expanded beyond medical world as many doctors brought with them, through their leadership, wider cultural concepts of spirituality and alternative practices (i.e. acupuncture, yoga, pranayama) to better health of the nation.

Our next steps includes recognising the role of women from within the UK and amongst migrants, in the NHS. 8 The Interim NHS People Plan needs to understand the aspirations and well-being for staff across boundaries and find sustainable solutions to continue to provide for the wide-ranging aspirations of the NHS Long term plan. Political leaders need to decide on the narrative for educating the public on the contribution of migrant health workers and crucial role they play in providing excellent care. NHS Employers and regulatory bodies need to clean up their acts in providing culturally sensitive support, demonstrate emotional intelligence and provide equal opportunities to reach one's potential. Brexit effect might create more opportunities in near future, if recent visa problems could be handled properly. The UK, as we know it today, is to a great extent the result of population movement. Migrants do not just bring a colourful presence, different cultures, music and food but shape nations by working in industry, public services and becoming involved in civil society. [10]
NHS is a role model for other countries including India are aspiring to. Evidence of that is seen in some reverse migration to India. Hopefully other countries will benefit from excellent leadership and patient safety experience in NHS. Our problems of the past are diminishing but new problems might replace them and we need to identify them so we could tackle them head on. Organisations such as BAPIO have a huge leadership role to play in the present and future of the NHS.

We would like to remind our readers what Swami Vivekananda advised

our next generations: 'Not to forget our Indian roots, with our spirituality as the base!'

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Revolutionising healthcare: the digital era

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Digital transformation in healthcare opens up a whole new language and itself can lead to differences in understanding and outcome. We could simply assume that this is the fault of managers, decision makers and digital leaders. Equally, the ground swell in the ecosystem of start-ups, small to mid-size enterprise (SME) and technology suppliers badging themselves under the umbrella of digital transformation can be equally confusing. Digital transformation has always been about significant transformation of activities and processes that capitalise on opportunities from digital technology. The impact of this change is intended to span society, it should be strategic and co-ordinated.

Making the case for digital transformation in health is itself complex, there will be uncertainty and unknown outcomes. It's a sector that is moving at such pace that making predictions about the type of technology and the type of benefit is difficult and relies on a mixture of insights, evidence and global trends. Digital transformation will inevitably mean different things in different settings, the ability to transform will be depending on culture, technology, legacy and funding as well as competing interests and priorities.

The use of technology in the NHS has made great strides in recent years; the NHS App is being rolled out over England this year, allowing patients to access their medical records, book appointments and order repeat prescriptions all from one place. Almost all GP practices and pharmacies are now live with the new Electronic Prescribing Service (EPS), and 111 online is helping to empower patients in choosing appropriate services for their care. These represent but a few of the many developments that have taken place in the last couple of years.

The NHS is in the early stages of utilising artificial intelligence and block chain technology. Decision support systems can aid clinicians in optimising prescribing practices. Personalised medicine incorporating genetic testing is beginning to make its way towards more mainstream usage. However, data will need to flow more freely between healthcare providers, planners and patients, this is where technology such as blockchain could be used to help aide data security.

These developments in the digital health ecosystem are rapidly advancing, and for the NHS to make good on its commitment to provide world-leading care, it needs to keep up. There is recognition that this cannot be done alone, and the technology sector will need to help health policy makers to solve some fundamental problems. The NHS wants to encourage innovation and foster a system that allows cutting edge companies to enhance the standard of digital health and care tools and services.

Clinicians are experiencing an ever-increasing demand for front line medical services. In addition to delivering hands on clinical care, the amount of associated administrative work has also increased. Clinicians of all disciplines and grades now spend a significant part of their time working through this tidal wave of paperwork. Often this involves having to sacrifice time directly with patients and, for more junior staff, sacrificing training opportunities.

The knock-on consequences of overwhelming our clinicians like this includes burn out, staff exodus and ultimately sub-standard patient care. The problem of administrative work will not go away but there is hope. The 'gift of time' is a major theme in the recently published Topol Review[1], emphasising the potential of technology to disrupt existing working practices and to hand back time to staff.

In some parts of the world, advances have been made in the use of technology to assist clinicians in transcribing consultations. A number of global technology providers specialising in natural language processing have initiated projects using voice recognition technology in healthcare.

Clinical decisions support systems which are integrated into electronic medical records may in the future become optimised through the use of real-world evidence. These are all exciting developments and require a constructive dialogue between the profession, industry and policy makers so that the outcomes are of benefit to patients.

The NHS is changing rapidly and initiatives such as the NHS Digital Academy, the NHS Digital Pioneer Fellowships and the NHS Clinical Entrepreneurs Fellowships; and now the Topol Fellowships demonstrate there is no shortage of ambition. The growth in digital health, transformation initiatives and development of workforce signals an important moment in the role of the professions supporting the digital development of the health system. ❑

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General Medical Council – A Responsive Regulator

Initiatives for delivering high quality care in a safe and supportive environment

Charlie Massey
Chief Executive, GMC

In launching the NHS Long Term Plan, Simon Stevens noted that almost everything in the plan is already being implemented successfully somewhere in the NHS. That's a good place to start, but how do we make sure that the best innovations and support reach those parts of our health system in greatest need?

It's a question we've applied much time and energy to at the GMC. In parallel with other NHS healthcare professionals, doctors have experienced significant turbulence as the effects of a system under pressure and unaddressed concerns beg questions about how staff are supported to deliver the care expected of them.

The GMC is not remote from those concerns. We've played a part in some of them, and I'm determined we will have a role in addressing them. Our entire strategy is geared towards giving more doctors the support needed to avoid harm, rather than acting after harm has come to them or patients. Recent events have only reaffirmed that the direction we have taken and intend to build on is the right one.

This year we've delivered towards commitments made in 2018 to improve the environment in which doctors work and address the impact of system pressures on medical practice. For example, we have published joint guidance with partners on reflective practice[1] and have surveyed (Specialty Associate Specialist) SAS and locally employed doctors[2] to find out more about the issues which matter to them. But our work has also shone a light on workplaces and cultures in which doctors work. As we have done that, we have sought to highlight examples of good practice, so we can replicate and build from them. Earlier this year Leslie Hamilton's working group published its review[3] into how the law is applied to medical manslaughter. We share this report's desire for a just culture in healthcare and acknowledge we have a crucial role in making that happen.

In June, Dr Doyin Atewologun and Roger Kline's research[4] into referrals of Black and Minority Ethnic (BAME) doctors to the GMC revealed that disproportionate levels may be driven by a range of factors including poor induction and support, and isolating working patterns. Conversely, these factors also protect other doctors, creating 'insider' and 'outsider' groups.

We have also published a workforce report[5] highlighting that UK healthcare is more reliant than ever on overseas doctors. In 2019, for the first time, more non-UK graduates joined the medical register than British-trained doctors. However, workload pressures and workplace cultures mean that the NHS does not always offer enough support.

Those doctors are making a huge personal and professional commitment to our health service by coming to the UK, and that's why we now offer our free 'Welcome to UK Practice' course[6] for all doctors joining the register. But we need to work with employers too to improve the consistency and quality of the support these doctors deserve. And we continue to lobby government to make changes to the law so that these and other doctors can more easily demonstrate that they satisfy our requirements for getting on to the General Practice or specialist register.

Finally, Professor Michael West has undertaken a UK-wide review of the factors which impact on the wellbeing of medical students and doctors [7]. All of these reports contain overlapping themes which need co-ordinated action. In the coming months we'll continue discussions with senior leaders across the UK about how we work together to implement recommendations as swiftly as possible. Crucially, many of the answers already exist in parts of our health system.

Bringing those answers together and helping to spread good practice is one part of our commitment to supporting doctors. Those intentions don't exist in isolation from the realities of day to day life in the health service; we, along with others, also have a role to play in helping the NHS to be a more flexible place in which to train and work, and where all doctors have access to development opportunities.

The next few years will see the GMC take on responsibility for regulating physician associates and anaesthesia associates; roles which, if developed with care, can alleviate some of the pressure doctors are experiencing.

Medical, digital and technological innovation will mean that clinical staff will need to work in new ways, with patients and with each other. We'll be there, making sure that our standards and guidance keep pace to support doctors in a changing healthcare landscape.

Regardless of the changes which take place in the health system in the next ten years, our commitment to you remains the same. We'll continue to support you in delivering good care to your patients by building on the work we've started to engender a culture of fairness, mutual support and strong clinical leadership.

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The invisible culture of discrimination

-Call it institutional racism or unconscious bias, it has a devastating impact on the victims

Satheesh Mathew, Vice President, BAPIO

A recent ITV news item featured Radhakrishna Shanbag, a senior surgeon with over 20 years of service in the NHS, being asked, 'Please can I have a white doctor for my operation?', by one his patient's. Any form of racism is both painful and upsetting, however to a dedicated professional it throws a much greater challenge. To remain professional, composed and objective in the face of adversity, is ingrained in medical training. I am aware of several instances of patients demanding to be seen by white doctors[1] One is also expected to provide the very best of care 'free from all bias' at all times to all comers. As in this case, professionals have no choice but to swallow the insults and provide alternatives to get the best possible outcome, suppressing the impact on self-worth and devastating emotional trauma.

You must have seen in the media of a Surgeon who was asked by a patient to provide a white doctor to treat him. The surgeon, while experiencing blatant exhibition of 'racism', seemed more to me in a predicament as he explained in a media interview, with and uncertainty about how the organisation would support him.

It is indeed worrying, if a highly trained professional, after two decades of service appears to have limited confidence in the NHS, when it comes to dealing with overt form of racism. However, after the item was aired there has been a twitter storm of opinions in support of the surgeon, clearly condemning this behaviour and prophesying that NHS has a zero tolerance policy to any form of abuse towards staff. There have also been #metoo stories of other professionals facing similar abuse in their own workplace.

There is a hidden side to discrimination that is perceived but often not understood or able to be clearly demonstrated. Yet, it is feared equally with far more impact on the career and personal lives of doctors, nurses and other healthcare staff. Often this is manifest in the form of poor supervision, level of mentorship/support and opportunities for progressing in careers. The NHS Workforce Race Equality Standard Report in 2018[2] highlighted the continued nature of the under-representation of Black & Minority Ethnic (BAME) staff in higher positions in the NHS.

This is compounded by the trend in the NHS of the deterioration in the working conditions often leading to recognised unsafe scenarios for care delivery.

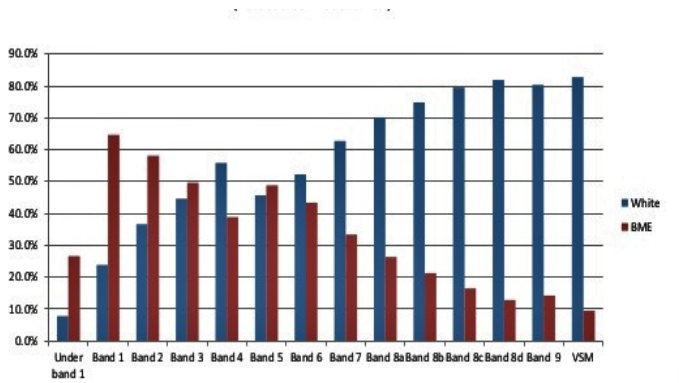

Figure: Percentage staff by AfC pay band and ethnicity for NHS trusts in London

Often this is related to lack of adequate resources. While I endorse these concerns, the real challenge lies in the systemic failures in ensuring that monitoring and accountability structures are robustly implemented across the NHS.

Over the years, British Association of Physicians of Indian Origin, has been inundated with inquiries and requests for advice and support from international medical graduates (IMG) at all grades and seniority. The most common among these, were the fear of discrimination and seeking appropriate mentorship. Many IMGs were concerned that the available organisational support structures were lacking in empathy and cultural competency. There was a perception of not being dealt with in fairness or openness expected universally.

More came to light when BAPIO, successfully petitioned the High Court against the attempt of the Government to introduce unfair and retrograde immigration rules. The changes in the "Highly Skilled Migrant Programme" ("HSMP") would have impacted on the careers of over 14,000 professionals, many of whom would have been sent out without qualification or a career under this proposed rule. Traditional organisations failed to provide appropriate support. We had to take the case up to the House of Lords, now the Supreme Court where a five member bench ruled in our favour. The careers of thousands of BME doctors were saved.

BAPIO established a not-for profit professional support organisation in 2010 in the name of Medical defence Shield (MDS). This is a project for doctors and run by doctors that is focussed on fairness and justice for all doctors in difficulty. This is a medical defence organisation and a 'trade union' under the same umbrella.

In 2014, BAPIO filed a judicial review against the Royal College of General Practitioners. The court heard that UK graduates from ethnic minority backgrounds were nearly four times more likely to fail the CSA, and international medical graduates were nearly 16 times more likely to fail than white UK graduates.

BAPIO did not win the case. However the conscience stricken judge in his judgement said ***"If RCGP does not act and its failure to act is the subject of a further challenge in the future, it may well be that it will be held to have breached its duty"***

There has been a flurry of activity among the Royal Colleges to show that their examinations are fair. However,

the statistics have essentially not changed.

BAPIO remains committed to 'patient care and safety'. We support leadership and professional excellence for all doctors including IMGs and doctors from black and the other minority ethnic backgrounds to strive to maintain high healthcare professional standards. And we are proud that these IMGs have been making significant contribution to sustain and develop the NHS. There was a strong demand for BAPIO to make its presence felt across the country. Over the years, we have developed a network of regional offices.

The recent case of 'Bawa-Garba' has reopened a Pandora's box of a number of systemic failures that the NHS has not been able to address.[3] The NHS and the regulatory bodies have a responsibility to ensure that working conditions are safe for both patients and the staff that care for them.

We have welcomed the NHS Long-Term Plan and its commitment to supporting NHS Workforce Race Equality Standards.

There is often a historical lack of trust in the processes of openness and fairness within traditional institutions. The NHS is not immune to this and hence the impact of this perceived institutional unfairness needs to be acknowledged by senior leadership and a clear message given to remove the culture that condones discrimination; institutional, direct and indirect or covert or unconscious bias.

We hope that the Interim NHS People Plan (within the NHS Long-Term Plan) [4] would invest in the wellbeing and support to the whole workforce and in doing so remove barriers to progression for all staff irrespective of their protected

characteristics including race, religion, sexual orientation or ethnicity.

To propagate a culture shift in the NHS governance structure that is both robust and sensitive to the needs of its employees; to enable them to deliver high quality care in a safe and just environment. ❑

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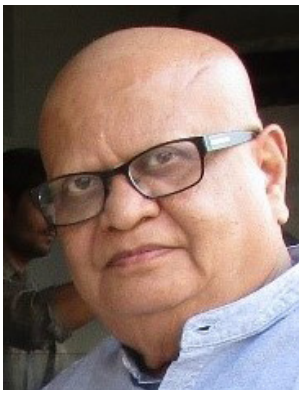
We stood for justice and fairness

BAPIO members and supporters at the protest before the Downing Street, London 21 April 2006

Insights from the GMC's 'Fair to Refer'



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The recent report commissioned by the GMC -'Fair to Refer' highlighted several issues. The report sighted inadequate induction and support from employers could be behind the high number of referrals of black, Asian and minority ethnic doctors to GMC investigations. *'Fair to Refer'* hopes to stop doctors getting caught up in unnecessary probes in the first place and focus on employers, rather than regulators or inspectors. While the report is generally welcomed by many organisations, one might think that this realisation is not new. The real problem may indeed be at Board level where Non-executive members often fail to take their corporate responsibilities seriously and hold the executive to account. In the absence of an effective mechanism for meaningful engagement with clinicians and front-line professionals, the blame culture and the unsupportive mindset may remain unchanged.

The NHS Workforce Race Equality Standard (WRES) published a report in July 2019, 'A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce.

It concluded that in the management of people-related issues and conduct of workplace relationships, there needs to be greater consistency in demonstrating an inclusive, compassionate and person-centred approach, underpinned by a concern to safeguard people's health and wellbeing, whatever the circumstances. It has flagged up the need for demonstrable leadership, accountability and support interventions to continuously improve on race equality. It is a credit to the WRES team that they have provided some valuable suggestions that may help deliver the twin priorities of reducing (a) the ethnicity gap in entry into the formal disciplinary processes, and (b) the overall levels of punitive action taken on all staff.

These report acknowledges the prevailing environment where employers are known to be more likely to refer doctors who obtained their primary medical qualification outside the UK and those who are from a black and minority ethnic background to the regulator, than they are to refer UK qualified or white peers. The situation is not much different amongst other healthcare staff and in many non-health related industries. Unfortunately in amongst healthcare workers the consequences are more severe, complaints from employers are more likely to result in formal investigations and sanctions. While the individual caught up in the episode is left in an environment of fear and persecution, often without any support. It is not fair for healthcare staff who are often working in sub-optimal conditions, infrastructural deficiencies or staffing shortages to face consequences of actions which are often dependent on circumstances rather than individual failing or malpractice. The report highlights the common fate of a BAME staff is that the matter escalates much faster to a formal internal process and thereafter, an inevitable 'referral to GMC'.

The recent highly publicised case of 'Hadiza Bawa-Garba' highlighted many aspects of poor induction, lack of supervision, unsafe staffing and systemic failures yet the nurse and junior doctor were scape-goated by the system. To be fair, this was a turning moment in the history of medical training, one that united all medical and nursing professionals; the subsequent review and recommendations has acted as a catalyst to change the very fabric of organisational responsibility and accountability.

The NHS Trust Boards have been shown in its functions to lack credible processes that provides for corporate and managerial accountability and implementation of good practices in most investigations. The cost to an individual are often too high and the loss in time and service are too precious to squander away.

The NHS faces a recognisable void, in the confidence staff often place in the management. The environment which often sustains a culture of suspicion, blame and fear has made it a poor employer, allowing unnecessary drain on what are limited resources that could be put to for improving patient care. There are some who suggest the NHS Trust Board to be made an elected body with Council of Workers to vote on the nominees.

This may require a major shift of political will but also involve the legal framework for amending the public appointment system that is currently prevailing. Meanwhile, some have advocated a different approach by suggesting that the NHS Trust Boards established an 'independent committee' to be a Conflict Resolution forum with specific remit to review Pre-investigation and Pre-referral to GMC recommendations of the Managers against any employee.

The latter option may be potentially viable facilitating mechanism for setting an investigation standard. Further, possibly may open a legitimate route for the workforce to raise issues relating to systemic challenges in nature involving patient care and safety. It can lead improvement in relationships and develop a meaningful consultation processes to help identify 'heat map' of conflicts! Often such bodies can facilitate staff from all walks of life, in feeling valued, sharing ideas and be part of local solutions.

The perception that staff have recourse to someone independent who may be holding senior management to account such as a Freedom to speak up Guardian, would go a long way in re-building trust in the system. It may be a useful exercise in confidence building and reduce the need to 'whistle blow' as a last-ditch act. For the NHS Trusts an independent 'watch dog' could provide an insight in to any potential hot-spots where clinical practices and safety may be compromised. ❑

Fair to refer: Key Findings & Recommendations [1]

- **Doctors in diverse groups do not always receive effective, honest or timely feedback because some managers avoid difficult conversations, particularly where that manager is from a different ethnic group to the doctor. This means that concerns may not be addressed early and can therefore develop.**
- **Some doctors are provided with inadequate induction and/or ongoing support in transitioning to new social, cultural and professional environments.**
- **Doctors working in isolated or segregated roles or locations lack exposure to learning experiences, senior mentors, support and resources.**
- **Some leadership teams are remote and inaccessible, not seeking the views of less senior staff and not welcoming challenge and this can allow divisive cultures to develop.**
- **Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates particular risks for doctors who are 'outsiders'.**
- **In groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). Members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.**

Recommendations

1. **Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums)**
2. **Ensuring engaged and positive leadership more consistently across the NHS**
3. **Creating working environments that focus on learning and accountability rather than blame**
4. **Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations.**
5. **https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer**

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Supporting Medical Students

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BAPIO young Doctors Forum successfully launched the first National Medical Education and Research in Training Conference (MERiT) for students and junior doctors at St George's University on 30th March 2019. Held in collaboration with Medical Colleges across London, the conference welcomed over 150 delegates from across the country and even as far afield as Hungary. Another 100 students and junior doctors were placed on the waiting list.

Following initial introductions by Dr Mehta, the conference opened with a keynote speech by Prof Dame Parveen Kumar and provided medical students and trainees career advice from leaders within the NHS. With the help of over 50 junior doctors, workshops covered a wide spectrum of themes including career progression, critical appraisal and broadening horizons. Students were given insight into the methodology behind the assessment of research articles and interpretation of results, as well as unique networking, career and educational opportunities.

Ongoing support and career advice to anyone wishing to receive further information will be provided by junior doctor mentors over the year.

All attendees were invited to submit poster abstracts with cash prizes for the top three posters presented. With the help of conference partners including Barclays Bank and Medical Defence Shield, and support from BAPIO, delegates were able to attend the conference without any charge and were also provided with lunch.

BAPIO young Doctors Forum members with Parveen Kumar and Ramesh Mehta
St George's University

Delegates at the conference organised by BAPIO young Doctors Forum - 30 March 2019

The feedback for the conference has been unprecedented with students praising the knowledge base of junior doctors, the quality of teaching, enthusiasm and energy, as well as the organisation and wide array of facets covered.

The hard work of the organising committee has led to the inception of a new conference to provide students and trainees comprehensive and useful information as well as cultivate new contacts; a platform has undoubtedly been created for the National MERiT

Mumbai Experience

BAPIO Research and Innovation Competition 2018 Winner

Khadijah Ginwalla
Year 4 MBChB
UNIVERSITY OF BRISTOL

I would like to begin by thanking the BAPIO team, especially Dr R Mehta for providing me with the amazing opportunity to travel to India for the 12th Annual GAPIO conference and securing an observership at the largest government hospital in Mumbai.

I began my ophthalmology placement almost immediately, at the Lokmanya Tilak Municipal General hospital, which is fondly referred to as "Sion hospital" by locals. I was lucky enough to witness first-hand how a hospital with over 1.5 million outpatients operates in an efficient and cost-effective manner.

The facilities and equipment used are very basic, however the principles of how patients are managed are very similar to those of the NHS. In the outpatient department, patients are first triaged by junior doctors who write the initial investigation and management plan.

Once investigations have been conducted (usually within a couple of hours), they are passed onto senior consultants who will proceed to go over what has been done and plan what happens next in the patient journey.

In the wards, I was privileged to see a huge variety of patients including those from the local Dharavi slum, considered one of the largest slums in Asia.

The eye problems ranged from cataracts, ectropion, glaucoma to complex corneal traumas. The principle of confidentiality is somewhat lost in such busy hospitals, where doctors and healthcare professionals refer to patients as their pathology and histories and examinations are taken in rooms full of other patients and their weary family members.

The style of consultations seems very paternalistic in India, whereas the NHS has moved to a more patient-centred approach to healthcare delivery. There were no theatre list administrators or coordinators as such, and so it fell upon the registrars and juniors to get together and compile the list for the following day.

This included preparing the anaesthetists beforehand over WhatsApp and skipping lunch to come prepare patients. The speed at which everything was organised continued to amaze me, especially after I was informed that Sion hospital performs world-class surgeries for a fraction of the western world's price.

I was given the unparalleled opportunity of being in theatre with a highly-skilled surgeon, who completed cataract operations in less than 10 minutes with ease, whilst simultaneously directing the junior doctors on the other side of the room, of how to best perform a dacryocystorhinostomy on another patient.

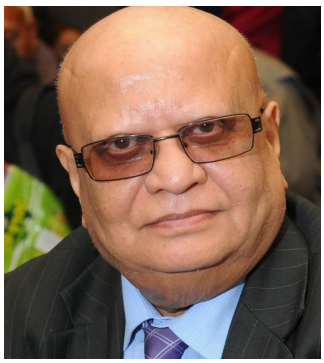
With classic Bollywood tunes playing in the background and the soothing sound of the ECG monitor beeping away, this placement was an eye-opening and truly heart-warming experience. It really embodied the Indian value of making the best of any situation even when stretched to the limits.

Following my placement, I was given open access to the three-day GAPIO conference which featured pioneering speakers and for the first time ever, the President of India, Shri Nath Ram Kovind himself! The talks were inspiring and intellectually stimulating from new surgical procedures and techniques, to interesting case reports and alternative management strategies.

The round tables were bursting with innovative ideas as how best to address the global shortage of healthcare professionals, with many international heads of prominent organisations present. It wasn't all hard work however, there were plenty of light-hearted moments in the evenings, cultural song and dance and an exclusive fashion show!

I am forever humbled and indebted to have been offered such a life-changing opportunity and would sincerely like to thank all those who worked so tirelessly to make this possible. ❑

Can Artificial Intelligence be a solution for the challenges faced by Indian Health Care?



Buddhdev Pandya MBE
Director of Policy, BAPIO
Member of New York Academy of Science.

India with a population of nearly 1.3 billion has unimaginable challenges in planning for a health care system. While accessibility in geographical terms is challenging for a huge country, the rich and affluent can access state of the art services, while lower- and middle-income population are left to face cruel choices, as the state health infrastructure remains sparse and grossly under-funded. The evolution of new quantum computing and its capitulation with robotic or molecular technologies is creating faster diagnostic and treatment algorithms. With the availability of satellite communications for remote areas and advances in accurate sensing gadgets, the possibility of providing rapid healthcare via artificial intelligence is becoming closer to reality.

"There is an emerging paradigm shift in how health conditions are diagnosed and treated. Advances with portable and simple to use medical devices/ technologies may provide the answer in reaching-out to communities living in geographically remote and economically deprived areas. One of the main challenges of India's health care provision has been severe limitation of financial resources.

This is further compounded by many others such as waste of resources, limited training opportunities for healthcare staff and ineffective delivery of plans. A culture change of policy towards 'patient-centric solutions' is needed if Indian health care is to take advantage of the new opportunities that innovations in artificial intelligence (AI) has to offer. In the search for answers, India must first integrate affordability as well as accessibility when addressing healthcare challenges!"

The net worth of the Indian health care sector is expected to rise threefold from US$ 110 billion in 2016 to US$ 372billion in 2022[1]. This growth driven by medical tourism, a burgeoning hospital sector, and increased affluence of a segment of the population, makes India an attractive prospect for medical device companies looking for partnerships. The Indian medical device industry has an opportunity to leapfrog innovations combining physical devices and integrated digital networks for far reaching benefit.

Indian in-vitro diagnostics (IVD) market consists of many different segments. There is an urgent need for affordable, portable, easy-to-use solutions in low-resource settings. The growth of the medical device industry is largely driven by the level of the healthcare expenditure, advances in technology and the need to serve an aging population with chronic diseases. For India with diverse inequalities in accessing basic healthcare, AI offers a unique opportunity. The health care industry presents a gap in trained clinicians and inadequate infrastructure that is compounded by low government spending. Yet, it a country with the most room for innovative, sustainable and scalable healthcare technology solutions.

In its last report (2019) telecom regulator revealed that India has 1.16 billion mobile subscribers, a notable penetration. This is indeed one of the most vantage points where the population equipped with smartphones can access digital technologies. We are witnessing a surge of smart wearable (wristwatches) devices that can track vital signs and alert the wearer/ provider, when the condition reaches set parameters. In developed nations, many aspects of remote monitoring of patient's wellbeing and treatment outcomes are already established. The rise in diabetes, heart and kidney disease in addition to the traditional scourge of infectious diseases provides a fertile substrate for AI solutions.

In February 2018, the Government of India announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by transforming existing Sub Health Centres and Primary Health Centres to deliver Comprehensive Primary Health Care and declared this as one of the two components of Ayushman Bharat (ref). These centres would benefit from a network for the integration of information; managing patients and their follow-up using AI. In local health planning such information would be invaluable and mobile units would be able to reach remote areas powered by portable technology.

The Ayushman Bharat - National Health

Protection, also intends to provide support for secondary and tertiary care hospitalisation for many poor and vulnerable families. A well-designed AI algorithm would help improve efficiency and provide basic healthcare to a larger cohort.

India has a history of embracing 'pilot schemes' of public-private partnerships that appear to be successful but eventually, few of them have been scaled up to meet India's health challenges[2]. In the last decade products for tuberculosis medication adherence monitoring and vital parameter monitors in the primary healthcare places with the telemedicine programs medical expertise has been providing without doctors the doctor being present. AI applications being developed and deployed in India include algorithms that analyse chest x-rays and other radiology images, read ECGs and spot abnormal patterns, automatically scan pathology slides and assess fundus photographs for signs of retinopathy.

In many countries, the healthcare systems are often slower to adopt change than their counterparts in other industries and insist on a higher rigour of testing for patient safety. But in India, it is not only regulation that stifles innovation. Most healthcare is provided by the private sector and paid for by the individual, hence affordability is huge challenge in adoption of new technologies.

Already in the USA Outcome-Based Contracts (OBC) are being implemented which is proposed as a measure to award innovation, based on the actual performance of treatments and interventions in real patients. This can be challenging as outcomes are often difficult to measure or quantify. AI has the potential to fill this gap. Developments in this area may support reimbursements under the proposed 'Modi Care scheme' consisting of an insurance cover for the poor.

- India needs a leap through innovative, sustainable and scalable AI technologies with the potential to improve outcomes through remote access, screening, prevention, and treatment for the deprived segments of population.
- The private providers and cutting-edge innovators need to be incentivised in shaping the advanced medical sector that India needs to attract medical tourism.
- AI and integration of outcomes data can support a culture shift towards patient safety and restore trust in the healthcare system.

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Artificial Intelligence Technology Futuristic Free Photo

Radiology Global Fellows:

An international response to the workforce crisis in radiology.

Dr Robin Proctor
Consultant Radiologist and Clinical Director for Core Clinical Services
University Hospitals of Morecambe Bay Foundation Trust

Why is there an issue? Radiology essentially facilitates diagnostic decision making and treatment in almost all aspects of healthcare. There has been an expansion in demand for imaging, around 10% year on year in CT and MRI since the turn of the century.{ref} Patients are now surviving for longer with multiple comorbidities as well as having a greater expectation to be better informed and involved in their healthcare decisions. These changes have led to a shift towards more complex imaging. Many older style imaging has been replaced by newer technologies higher technical equipment and expertise to interpret. Finally there are some factors such as following up incidental findings or public screening for early detection of diseases which require serial imaging.

Aren't we going to be moving to AI? Artificial intelligence and machine learning will benefit patients in medical imaging and radiologists who use this technology may replace those who don't but this is some distance off and radiologists to oversee the processes will still be required. There remains a gap in interpreting images for cancer and other similar pathologies in almost every trust in the land. (Only 2% of trusts meeting current demand through radiologists' contracted hours alone.){ref}

What about radiographers reporting? Radiographers are also a shortage group and are already busy managing the increase in images being acquired. Radiographers make a further valuable contribution by taking on specialist roles including reporting, but is insufficient to meet the demand and a medical training remains necessary to interpret and guide treatment for many patients.

What is the Global Fellows Programme? This provides Radiologists with an opportunity to work in England as a Global Fellow for a period of 3 years. Global Fellows perform a mixture of independent service work (60%) and develop their skills in a subspecialty (40%). Completion of CESR is at their discretion and early experience is that this is popular both as a credential and for future career planning. The three year Global Fellowship is a placement, not a migratory programme.

This scheme is delivered through a partnership between Health Education England, The Royal College of Radiologists, Apollo Radiology International (ARI) and University Hospitals of Morecambe Bay NHS FT (UHMB). Following a successful pilot at UHMB (4 radiologists, all still in post), a larger group of Global Fellows have accepted posts at other trusts across England and are in the final stages of induction before taking up their jobs in the UK . (24 offers made in this cohort) The scheme is being further expanded across the country. An anticipated further 50+ radiologists will become available in January 2020 after a bespoke sitting of the FRCR examination and placements are currently being sought and assessed for them.

What is required of the radiologist? Technically the scheme requires independent competence in general radiology and is open to radiologists who have completed Fellowship of the Royal College of Radiologists (FRCR, a PLAB-exempt route to GMC registration). The key personal attributes are an understanding of the programme, a wish to experience NHS working life and a willingness and ability to adapt and learn the professional and interpersonal skills to support this. The induction runs in Hyderabad, India and assumes previous training or practice in radiology within India.

What do trusts need to do? A Trust would need to be able to sponsor a Tier 2 visa, provide mentorship, opportunities for learning and discussion with colleagues and practical help with accommodation, schooling and other pastoral support. The specialist interests of the Global Fellow are matched with the requirements of the trust during the recruitment process. Global Fellows go through a central recruitment process assessing professional values and transferable skills. They will be appointed with individual contracts of employment with host trusts and information packs to facilitate trusts delivering this are provided as part of the scheme. Experience suggests there are benefits to small cohorts so preference is given to trusts who wish to appoint a number Global Fellows.

There is a multi-phase induction for a month in duration, hosted by Apollo Radiology International in Hyderabad. This will support them through the various language, General Medical Council (GMC), Tier 2 visa and acculturation requirements. Their technical competence has been demonstrated through the FRCR qualification and although learning around MDTs, drivers for imaging in the NHS and reporting style are covered the induction is predicated on them already being a technically competent radiologist.

What are the arrangements for pay? Trusts would be expected to pay the Global Fellows' salary. The UK's experience of radiology being a shortage specialty is not unusual and there is a global market. Local negotiation and consideration of experience may be necessary although to be competitive, a point on the staff and associate specialist (SAS) scale just less than the starting point of the consultant scale is typical.

How is this different from locum consultant posts?
Global Fellow posts are for radiologists who, although experienced and competent outside the UK, are not on the specialist register and consequently are not consultants. Many agencies would like to place similar candidates in a consultant post in return for hefty commission but this disenfranchises those who are on the specialist register, does not develop the radiologist in a supportive way and exposes patients to potential harm. Although not initially on the specialist register and still developing many of the soft skills of being an NHS consultant the programme is educational and it is likely that many will finish their posts at a similar level to a consultant. As above, CESR is optional.

Is there a clash with trainees? In almost all cases there is more than enough work to go around. Global Fellows may be experienced in teaching and with suitable training and accreditation could support sustaining trainees within a department which would otherwise be unable to do so.

What about efficiency? The scheme developed from a wish to have a more cohesive, self-supporting and sustainable team and the principal justifications are in terms of quality and sustainability. Modelling demonstrates that this scheme is cost efficient in comparison to the alternatives of more expensive locums and outsourcing of image reporting.

Questions or want to get involved?
global.fellows@mbht.nhs.uk

Mindfulness for Healthcare Professionals

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Heavy demands on health care staff include dealing with a large number of patients, long hours, restricted control over the working environment and ongoing organisational changes. Such conditions have been directly associated with growing stress levels and symptoms of burnout amongst health care professionals, and consequently, affecting the quality of care delivered to patients.[1] The good news is that this is now increasingly recognised and is indeed a catalyst for change in the development of awareness aimed at building self-care skills for clinicians. In particular, there is a growing body of evidence in Mindfulness-based interventions, which have a potential role in reducing stress and burnout.

But what is mindfulness? There are many definitions of mindfulness but perhaps the most succinct and widely used, was coined by Professor Jon Kabat Zin of the University of Massachusetts Medical School.[2] It is the awareness that arises through 'paying attention, on purpose, in the present moment, non-judgmentally.' This essentially translates to a way of being in the world in the 'here and now' by giving your full attention to what is happening in the current experience. Mindfulness is about cultivating a greater sense of self-awareness through building a deeper connection with our bodies and emotions, and a stronger presence within our immediate environments. You have probably experienced it before, whether you recognised it as such or not. Think of a time when you were fully engaged in an activity like writing, playing sport, reading or creating art that your entire being focused on that one activity. This heightened state of attention is mindfulness.

Isn't it a bit touchy-feely? Indeed, there are many myths surrounding mindfulness. Some common misconceptions are; it is a way of blanking your mind or going into a trance or even that it is controlling your thoughts to think positively and merely a relaxation technique rooted in ancient religious beliefs or esoteric spirituality. Whilst the origins of mindfulness stem from Buddhist and Hindu meditation, the practice itself is completely secular, it is essentially teaching life skills for coping with the human experience which has gained respect and credibility in therapeutic terms.

Over the past twenty years mindfulness has been the subject of more controlled clinical research [3]. It has been proven with scientific rigour in the treatment of a number of psychological and physical conditions. It can help manage a number of mental health disorders, including anxiety and depression. The Oxford Centre for Mindfulness has found that Mindfulness-Based Cognitive Therapy (MBCT) prevents depression relapse in recurrent depression. The National Institute for Health and Clinical Excellence (NICE) has recommended MBCT in their Guidelines for Management of Depression (2004, 2009)[4] for service users who have had three or more episodes of depression. Other research shows significant improvement in burnout scores and mental well-being for a broad range of healthcare providers using mindfulness-based stress reduction education.

And it can help achieve a sense of calm in our overloaded daily lives. By increasing self-awareness particularly of one's stress levels through understanding one's own emotional and psychological triggers creates a pathway to be responsive to situations rather than reactive. Greater self-awareness also helps to increase ability to reflect and subsequently take proactive measures to improve one's boundaries in the workplace and resolve conflicts as well as attending to others including yourself and service users with more compassion. And let's face it we are often good at extending compassion for others, but not so much for ourselves. Where mindfulness can feel like self-care, self-compassion can often be mixed up with feelings of self-indulgence[5] and therefore can be overlooked, yet it is crucial for clinicians.

But there is a growing interest in mindfulness for self-compassion especially in a healthcare setting where clinicians can be vulnerable to stress overload and compassion fatigue owing to the emotionally exhausting environment [6].

Having compassion for others requires having compassion for oneself and a common sense of humanity. Beddoe & Murphy [7] found that nurses who participated in a Mindfulness-Based Stress Reduction program reported that their mindfulness practice helped them to develop more compassion and empathy for their patients, and also helped their own self-compassion so they didn't take on the negative emotions of their patients. In another study, Shapiro et al [8] also found that health care professionals who completed a mindfulness program reported an increase in feelings of self-compassion and reduced stress.

Both mindfulness and self-compassion involve promoting an attitude of curiosity and nonjudgment towards one's experiences. Research suggests that mindfulness interventions, particularly those with a focus on compassion has the potential to increase self-compassion among health care workers, which in turn, shows promising results for reducing stress and increasing the effectiveness of clinical care. [9]

Whilst mindfulness may not be a fix to "cure all" for everyone, it is a way of meeting our experience with the presence of mind to respond skilfully to life's challenges, rather than reacting based on intense emotions. And with growing stress levels and burnout amongst health professionals, and increasing evidence that they could benefit from mindfulness interventions what is there to lose?

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Privatisation of NHS:
When Did It Truly Start?

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Is the Health Service on sale? The recent anxieties around Brexit and politicising of the NHS is not new. But, does it tell us the true story about how we can genuinely deliver healthcare service that is free for all at the point of access? With a budgetary spend of nearly 30% and ever increasing life expectancy, we will continue to face the challenge of funding health service as it exists today and for coming generations.[1] The Nuffield Report [2] enumerates the current challenges as an ageing population, a growing population, evolving healthcare needs, such as the increase in cases of obesity and diabetes, or antibiotic resistance, medical advancements (costs the NHS at least an extra £10bn a year), closure of local services due to centralisation drives and an increase in reliance on privatised services.

To address this, let's take a look at the evolution of healthcare in UK ever since the NHS was born on 5th July 1948. At the time it was a fundamental shift that allowed access to free healthcare to all and was no longer a privilege of the few. It had three key pillars or 'tripartite system' which comprised of the hospital services, primary care and community services. Of these three pillars, the GP's even then were independent contractors and were paid for each patient on their list rather than a fixed salary. Besides GP's, dentists, opticians and pharmacists also provided services under similar arrangement. These were overseen by the executive councils which managed the list of providers, contracts and payments.

Whilst it made healthcare accessible to all, the financial strains were felt within a few years. Four years later in 1956, this resulted in introduction of first prescription charge of 1 shilling and one pound to access dental service.[3] The emotions and battles of prescription charges continued as they were removed and reintroduced with exceptions over the following decades. Then eight years later, the concept of 'efficiency and economical use of public funds' was first introduced in Guillebaud's report in 1956.[4] At the time, NHS received almost a tenth of the Chancellor's budget.

During the following decades various other changes were introduced, however NHS still remained within public sector despite the wave of privatisation during the Thatcher era. However, despite patients receiving free care, there were no standards of care set against which the care delivery could be benchmarked. The patient charter was published in 1991 which for the first time outlined the patient's rights and responsibilities.[5] To deliver the assured patients' rights engraved in charter at all points appeared to be an impossible task. This led to a series of initiatives and publications of white papers during the Blair era to cut down the waiting times for access to emergency and elective services.[6] During this period under the private finance initiatives, private companies grouped together to not only finance and build hospitals, but also provide medical services such as ' urgent treatment centres' or provide non-medical staff such as catering services. Besides, there were targets set for primary care providers to seek around fifteen per cent of services from private and not for profit providers. This also led to other initiatives such as 'Choose and book' system and targets for emergency and elective services. During all these years, the budgetary spend had escalated from around 11% in 1948 to around 30% in 2018. Despite the involvement of private sector, patients continued to enjoy care that is largely free at point of access.

How do we fund such a mammoth undertaking that is sustainable for coming generations? Currently, we spend every 30 pence from one pound of tax payers fund to deliver healthcare that continues to remain free for patients. During the last seventy years, the nature of patients need for services has changed. Unlike then, when heart disease, stroke and infections were leading causes of mortality, now it is cancer and dementia which require long term care and support and have few cures. Without tripling tax payers spend to fund NHS, that offers free care to all, what models of care would make this a sustainable undertaking? Is marketplace a solution or part solution to the problem?

The concept of internal competition has existed throughout its history but was more formalised in late 1980's. By general economic principles, more competition introduces choices for the consumers. It can deliver timely efficient care whist maximising the return to every pence spent by tax payers. However, it comes with its flaws as seen in case of Circle Healthcare when managing

Hinchingbrooke Hospital.[7] The company said that funding for the trust had been cut by about 10% and an inspection by the Care Quality Commission reported that patients at the hospital were being neglected, hygiene was inadequate and there were severe staffing problems.

According to the recent King's fund report, in 2018/19, NHS commissioners spent 7.3% of the budget in procuring services from private providers including the voluntary sector. This has remained stable for the last two years. However, there is relative lack of data and clarity on how to derive accurate figures for proportion of budget spent in procuring services from non-NHS sector, both private and voluntary. If we include primary care services, then the figure may be closer to 25%. [8]

With the Health and Social care Act of 2012, all providers for regulated services have to operate to the same standards and governance processes. So, if the governance and monitoring standards for the NHS providers and the private providers of NHS contracted services are same, then why do we fear private providers? To address such fundamental question that is more fact based and has less media spin, we desperately need high quality unbiased large population based studies to understand patient expectations to develop healthcare models that allow us to deliver free healthcare for vast majority of services at the point of access. ❑

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Global Healthcare Summit (GHS)

BAPIO delegations attended the Global Healthcare Summit (GHS), organized jointly by Global Association of Physicians of Indian Origin (GAPIO) and American Association of Physicians of Indian Origin (AAPI) was held on 28th - 30th December 2018 at Hotel Trident, Nariman Point, Mumbai, India.

Dr Ramesh Mehta OBE, President of GAPIO and also, President of BAPIO welcomed the Hon'ble Shri Ram Nath Kovind, President of India who inaugurated the conference. Other guests included Hon'ble Shri C Vidyasagar Rao, Governor of Maharashtra and Hon'ble Shri Devendra Fadnavis, Chief Minister of Maharashtra were present.

Hon'ble President told the delegates - how does one achieve that perfect triangle of quality, cost and access? One way is to build alliances – between doctors and patient groups, between civil society and industry, between researchers and practitioners and ultimately between countries.

Hon'ble President was further concerned about another shared challenge of life-style diseases – such as diabetes and obesity – which is a serious public health issue both in India and the US. The prevention and management of life-style diseases offers scope for cooperation, including by bringing traditional Indian wellness practices to modern medical systems.

Pharmacist as an integral member of the Medical Team:

-An opinion on changing perceptions of extended roles

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Pharmaceutical products account for the third largest spend for the National Health Service (NHS), with the bill in England alone, exceeding £17 billion per year[1]. Majority of patients admitted into hospital take medicines or will have at some point prior to their admission. So, predictably pharmacy and in particular the pharmacist in the NHS 10-year plan, is defined as having "an essential role to play"[2].

NHS reformers are looking to pharmacists to help tackle the on-going dilemma that is an ageing population, rising co-morbidities and a shortage of doctors and nurses. In fact, my current role as lead pharmacist for polypharmacy and designated Primary Care Network (PCN) fit into transformation plans. Pharmacists are primed to deliver on the aspirations of the NHS Long term plan with a reach that extends beyond previously designated roles. Our coverage is pervasive, with expanded roles in domiciliary care, medicines administration, medication safety, electronic prescribing, clinics, ward rounds, monitoring of high cost drugs and funding, quality assurance, theatre and anaesthetics.

Since joining the General Pharmaceutical Council (GPhC) register in the summer of 2015, I have worked in different trusts across several specialities. More recently I completed a clinically enhanced independent prescribing course and whilst performing physical examination on patients, I was bemused by a variety of responses when I introduced myself as the pharmacist. On hindsight, this was probably unsurprising and reflects the public perception of traditional pharmacy roles.

We live in a generation of pervasive media domination of public opinion, at the forefront of this are medical dramas and documentaries, which to an extent influence people's insight into professional roles. In 2015, a study to determine how pharmacists were depicted in the broadcast media in the United States of America between 1970 and 2013, found that of the 231 pharmacist portrayals identified, 145 (63%) were negative roles, 56 (24%) were neutral, and 30 (13%) were positive. Additionally, very few pharmacist characters were ever cast in recurring roles.[3,4] Even within St Georges Hospital where the Channel 4® documentary '24 Hours in A & E'5 is filmed, pharmacists have not yet been featured, despite being a regular member of the frontline healthcare team.

To the general public, a pharmacist is defined as "a person one can go to when one needs a prescription or something for a minor ailment" but that is a tiny part of the job of a modern pharmacist. How can the profession change the public perception? Will the NHS 10-year plan change this, and should we expect to be more visible in the forthcoming years?

As exciting as the continued growth potential of the profession is, especially in secondary care, pharmacists do have the potential of developing an identity crisis. For years pharmacists have worked hard to be integrated into the multi-disciplinary teams. With the crossover of roles between the dispensing pharmacist vs the prescribing pharmacist, we risk becoming the profession with a confused or indeterminate identity within the health service to the public.

I believe we need to be advocating what our profession does, more than merely 'showing an advert of informing public to access chemist for minor ailments, to reduce hospital encounters'. We must and should create awareness of our profession as a vital, indispensable pillar supporting the NHS.

I started this piece trying to determine what the general public might define what a pharmacist is, so it seems fitting to end it with a pharmacist's definition of a pharmacist. For me, I am a medicines specialist that can act in many different roles, spanning from being a friendly person to converse with, providing a listening ear for patients to a supportive role in therapy. Fundamentally, my aim is to make medicine use more effective both clinically and financially and to improve the NHS ability to provide care to those who need it, when they need and for as long as they need it. That for me is integral in keeping the NHS the great institution that it is. ❑

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BAPIO Regional Activities



Pictures (L) 1: Rohit Vadhawan, First Secretary (Economic), High Commission of India London addressing the delegates. 2: Tamorish being felicitated at Bapio SW Conference for being elected as President elect of ASEM by First Secretary Rohit Vadhawan with Parag Single and Ramesh mehta OBE. 3: Clare Gerada MBE addressing delegates 4: Jenny Vaughan addressing delegates at the BAPIO SW Conference Bristol. Below: Delegates and guests the Conference. Parag Singhal Addressing the delegates and a Discussion Panel at the Conference - Organised by South West BAPIO at Leigh Court on 28th September 2019.




BAPIO Regional Activities

BAPIO jointly organised a conference in partnership with Bedford Hospital NHS Trust on 28th July 2019 at the King's House, Bedford on the theme 'Improving Patient Safety by promoting Equality & Diversity'

Delegates during the Conference

Mr. Stephen Conory speaking at the conference

BAPIO President Dr Ramesh Mehta

Speakers at the conference

BAPIO at RCPCH Annual Conference

BAPIO held a popular hot topics session at the RCPCH Annual Conference on 13th May 2019 at the International Convention Centre in Birmingham. Hot topics session by BAPIO has become one of the most popular sessions during RCPCH Annual Conference. Prof Russell Viner president RCPCH, was the keynote speaker. He explained the shape of paediatrics in 2040. Other topics included sepsis as a major challenge, mental health for busy paediatricians, recent advances in epilepsy management and asthma. Ramesh Mehta thanked the organising committee consisting of Arvind Shah, Amit Gupta, Prabhu Rajendran and Satish Mathew for organising this event.

BAPIO and RCPE Conference- Scotland.

The BAPIO Scotland and RCPE held a successful joint Annual Conference on Saturday 18 May 2019 at the Royal College of Physicians of Edinburgh. The meeting was also held in conjunction with the General Medical Council. Prof. Parag Singhal spoke about BAPIO's ambitious plans with the MTI scheme. Prof Derek Bell, President of the RCPE spoke about the importance of analysing big data responsibly. Claire Light, the Head of "Equality Diversity and Inclusion" in the GMC also spoke about the various current initiatives of the GMC. Prof. Raj Bhopal explained the features of higher risk of Cardiovascular risk in South Asians. Rebecca Clarke highlighted the feature of the "Welcome to UK" programme. risk in South Asians.

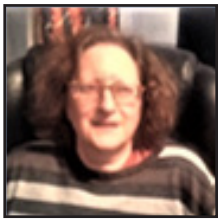
British Association of Physicians of Indian Origin

BAPIO Awards 2019

ACADEMIC EXCELLENCE
Prof Martin John Steggall

PROFESSIONAL EXCELLENCE
Prof Andrew Goddard

PROFESSIONAL EXCELLENCE
Dr Jeny Vaughan



OUTSTANDING CONTRIBUTION TO EQUALITY & DIVERSITY
Dr Hillary Klonin

IMRAN YOUSAF MEMORIAL AWARD SUPPORTING DOCTORS
Mr Amandip Sidhu

OUTSTANDING SERVICE TO BAPIO
Prof Mahendra Patel

EXCELLENCE IN RESEARCH & INNOVATION
Prof A A S Shetty

PROFESSIONAL EXCELLENCE
Ms. Elaine Tait

EXCELLENCE IN LEADERSHIP
Mr Raj Jain

CHARLES DERBY AWARD FOR YOUNG DOCTOR'S LEADERSHIP
Dr Dev Chauhan

WOMEN'S ROLE MODEL
DR Uma Gordon

Awards to be presented on 23rd November 2019
during BAPIO's Conference Dinner
at Edwardian Radission Blue
Heathrow, London

Medical Defence Shield: A Unique Initiative

Medical Defence Shield (MDS) is a unique Medical Defence Organisation (MDO) which was launched by BAPIO in 2010. The singular aspect of MDS is unlike that of any other medical defence organisation, Medical Defence Shield provides both Clinical Defence and Employment Support under one umbrella at competitive rates.

This approach ensures that both medico-legal and employment issues are handled in a holistic manner to support members who find themselves in complex situations.

In the current regulatory climate, it is wise to have experienced and personalised support when you need it most and our dedicated team of specialist advisors are on hand to ensure the best possible professional outcome for you.

A significant proportion of MDS casework has involved defending members before the GMC, representation in trust disciplinary proceedings and MHPS investigations and providing advice on medico-legal issues, complaints and coroners' inquests. MDS also has ACAS trained mediators on our team who have helped in obtaining local resolutions and mediation.

For more information, call today or visit our website.

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