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SUSHRUTA

MAGAZINE FOR DOCTORS AND DENTISTS

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British Association of Physicians of Indian Origin

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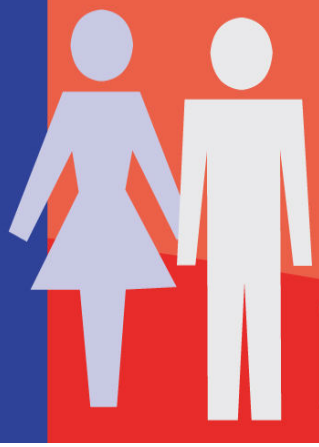

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Note: Cover-page picture with the permission of Dr Bawa Garba

Welcome Message

Prof Parag Singhal
MD, MPhil, FRCP, FACP
Organising Chair
Chair BAPIO South West
Hon Secretary BAPIO

Mr Sanchit Mehendale
MS(Ortho), FRCS(Ortho)
Organising Secretary

Dear Friends and Colleagues, Namaste!

On behalf of BAPIO South West, it gives us a great pleasure and an honour to extend our warm welcome to you all to the 2018 BAPIO Annual Conference, Bristol.

Bristol is a city straddling the River Avon in the southwest of England with a prosperous maritime history. Its former city-centre port is now a cultural hub, the Harbourside, where the M Shed museum explores local social and industrial heritage. The 19th-century warehouses along the harbour now house restaurants, shops and cultural institutions such as The Arnolfini, a contemporary art gallery.

One of the UK's most popular tourist destinations, Bristol was selected in 2009 as one of the world's top ten cities by international travel publishers Dorling Kindersley in their Eyewitness series of travel guides. The Sunday Times named it as the best city in Britain in which to live in 2014 and 2017, and Bristol also won the EU's European Green Capital Award in 2015.

The 2018 Conference is jointly hosted by BAPIO South West and BAPIO Wales. BAPIO conferences over the years have raised issues pertaining to disproportionate referrals of Ethnic minority doctors to GMC and differential attainment in College exams especially RCGP. BAPIO has never been shy of raising difficult issues, as was evidenced in the recent cases, and this year is trying to tackle the difficult issue of providing quality care within the available resources which are always going to be finite.

Public and NHS staff have been led to believe that more funding is the answer to the problems of the NHS. Whilst we recognise the need for extra funding especially in the social sector, there is increasing acceptance that resources in the NHS are not utilised efficiently. Given the enormous wastage, is the demand for more funding justifiable? Should we not work to avoid or minimize the wastage and offer a different narrative which is not based on asking for more and more?

The theme of this year's Conference "Affordable Care- The Holy Grail' will underpin the need for Collaboration, Prudence and Innovation in reducing the cost burden, by utilising the existing workforce to the maximum effect and achieve a sustainable health care. Our attempt is to showcase the pockets of innovations, which often go unnoticed, but can bring substantial benefits, if implemented across the system.

As the NHS completes its 70th anniversary, amidst the celebrations, there are genuine concerns and questions being raised about the sustainability of this care model, which is the envy of the world. We, at BAPIO, strongly believe in a State funded system free at the point of usage and are starting, in collaboration with likeminded organizations like OurNHSourConcern to offer a set of possible solutions, which address the fundamental issues like financial challenges, quality, workforce issues and low morale.

BAPIO 2018 will provide a wonderful forum for shared learning, and to refresh your knowledge base and explore the innovations in the delivery of health care. The conference will feature some of the doyens of the medical world people you may have heard and met before and some young guns too, who are climbing the ladder to prominence very quickly! The Conference will strive to offer plenty of networking opportunities, providing you with the opportunity to meet and interact with the medical leaders, administrator's, innovators, friends and colleagues as well as sponsors and exhibitors.

We hope you will enjoy the conference full of outstanding panel discussions, and take a little extra time to enjoy the spectacular and unique beauty of this region. We wish you a very pleasant stay in Bristol.

With Best wishes and warm regards

Prof Parag Singhal
Organising Chair

Mr Sanchit Mehendale
Organising Secretary

Editorial Message

Dr Mangla Mundasad

Dr Gangadhara Bharmappanavara

Dr Sahana Rao

The 2018 BAPIO Annual Conference takes a close and uncompromising look at affordable health care and digital innovation. These phrases are not new – indeed many of us may read them without giving a passing thought to what they really mean. They may have become the healthcare buzz words of our time.

But we are sure everyone shares our hope that the first phrase 'affordable healthcare' stops being a question rather than unwavering reality. And that the second phrase, 'digital innovation' will help produce and deliver the high quality, cost-effective healthcare that everyone deserves.

This conference is a moment to reflect on the shape of the NHS we want to work in and the NHS we want our patients to be treated in.

For 70 years, the National Health Service has been known for its noble and coveted aims – to deliver universal health care for all, irrespective of age, race and social status.

But in 2018, the very existence of the NHS is being challenged by a rising costs of services, an ageing population, lifestyle factors, successive winter crises and a marked change in public expectations. If the current situation continues without radical change, the NHS could face debts up to 30 billion pounds by 2020 (NHS Five year Forward View, May 2016), making this much loved institution unsustainable.

As innovations gather pace, the NHS is moving from a manual system towards digitalisation; the hope is this enables professionals to improve communication and patients to access the care they need more efficiently. NHS England is fully committed to implementing collaborative and coordinated innovations and advances in digital technology (Next Step on NHS Five Year Forward View-2016; Harnessing technology and innovation). But with each new innovation comes new challenges – from privacy to budgets.

The population of the UK is increasing at an average rate of 0.59% each year (worldometers.info). And at the same time, people are living longer. With these improvements in life-expectancy comes an increasing pressure on scarce resources. The NHS is facing a major workforce crisis with a reduction in staff numbers. To cope with this crisis, the NHS has been hiring staff who have trained outside the UK. 12.5% of NHS England's staff are from overseas (House of Commons Library, Number 7783, Feb 2018). Since the referendum the number of new nurses coming from the EU to work in the UK has dropped by 87% from 6,382 in 2016/17 to 805 in 2017/18 (Nursing and Midwifery Council; The Health Foundation). A survey of 1720 doctors from other European Economic Area (EEA) countries working in the UK carried out by BMA at the end of last year found that almost half (45%) were considering leaving as a result of the referendum vote (BMJ 2018; 361). With this current picture in mind it is an important moment for the eminent and experienced panel to enlighten us on the current healthcare workforce recruitment crisis around the world; the challenges this poses and the possible solutions it brings.

Hardly anyone will have failed to notice that the bruising junior doctor strike and the concerns raised by the Bawa-Garba case have had a significant impact on junior doctor morale. In his article, Dr Mehta provides unique insight & discusses learning points from these significant moments. Recognising the need for more trainee support, this conference has a day dedicated specifically to trainees, highlighting issues pertaining to junior doctors; discussing current and future training pathways and as a space to share learning and ideas to improve trainee morale. Meanwhile the BAPIO Research and Innovation Conference showcases some great work done by medical professionals – juniors and seniors alike.

We have eminent speakers at the conference discussing novel solutions that could make health care affordable – a critical challenge of our time. The conference also provides a great platform to interact

and exchange views with BAPIO members and we hope is a moment to reflect and engage in issues that are dear to us all and an excellent learning experience from expert colleagues.

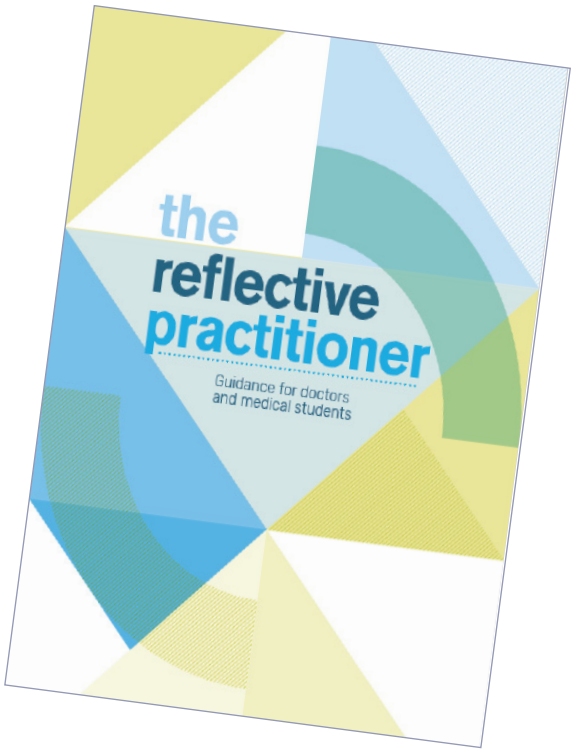
We sincerely thank our president Dr Ramesh Mehta, for supporting us with the 21st National Annual Conference. Our special thanks to Prof Parag Singhal, National Secretary and organising Chair, and everyone in the organising committee who have contributed in making this event a success. And a very special thanks to all those delegates who have made the time to come to and contribute to the conference.

Hope you all have an enjoyable conference.

Editorial Team

Dr Mangla Mundasad **Dr Gangadhara Bharmappanavara** **Dr Sahana Rao**

GMC: Guidelines For Doctors and Medical Students



This short guide supports medical students, doctors in training and doctors engaging in revalidation on how to reflect as part of their practice. It has been developed jointly by the Academy of Medical Royal Colleges, the UK Conference of Postgraduate Medical Deans (COPMeD), the General Medical Council (GMC), and the Medical Schools Council.

https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/the-reflective-practitioner---guidance-for-doctors-and-medical-students

Academy and COPMeD Reflective: Practice Toolkit
http://www.aomrc.org.uk/wp-content/uploads/2018/08/Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf

Ten key points on being a reflective practitioner:

1. Reflection is personal and there is no one way to reflect. A variety of tools are available to support structured thinking that help to focus on the quality of reflections.
2. Having time to reflect on both positive and negative experiences – and being supported to reflect – is important for individual well-being and development.
3. Group reflection often leads to ideas or actions that can improve patient care.
4. The healthcare team should have opportunities to reflect and discuss openly and honestly what has happened when things go wrong.
5. A reflective note does not need to capture full details of an experience. It should capture learning outcomes and future plans.
6. Reflection should not substitute or override other processes that are necessary to record, escalate or discuss significant events and serious incidents.
7. When keeping a note, the information should be anonymised as far as possible.
8. The GMC does not ask a doctor to provide their reflective notes in order to investigate a concern about them. They can choose to offer them as evidence of insight into their practice.
9. Reflective notes can currently be required by a court. They should focus on the learning rather than a full discussion of the case or situation. Factual details should be recorded elsewhere.
10. Tutors, supervisors, appraisers and employers should support time and space for individual and group reflection.

Foreword by President

On 5 July 1948, the National Health Service came into existence. 70 years on, it continues to be there for patients and communities. Its core values have stood the test of time: comprehensive care, free at the point of use, delivered on the basis of need rather than the ability to pay. We at BAPIO are proud to be part of this national institution and committed to providing high quality patient care.

Of course, there will be problems in any institution of this size. The recent case of Dr Bawa-Garba had a significant impact on the medical fraternity. It exposed many serious shortfalls that have been bubbling under the surface. It also uncovered the susceptibility of staff to untoward incidents. BAPIO played a significant role in this saga and stood up for fairness and justice. Thankfully the victory in the appeals court has opened a way for justice to Dr Bawa Garba and equally importantly set a precedence for future cases. We hope that various enquiries and reviews commissioned by DH and GMC will lead to better and more transparent approach promoting 'no blame culture'.

BAPIO has recently launched an Indo-UK Healthcare Policy forum at the Indian High Commission, London. We plan to proactively contribute to the healthcare policies in the UK as well as in India. If you are interested in this endeavour, please do get in touch.

Bullying and harassment of NHS staff continues to be a significant problem. We are looking in to finding a solution in collaboration with WRES, GMC and NHS Employers. Interestingly our recently formed unit in Isle of Wight have formed a local ani-bullying committee. If successful, this can be a role model to be extended.

DH has approached BAPIO for assistance with medical manpower shortages in the NHS. We do not encourage brain drain from India, but we are supporting 'Earn, Learn and Return' programme of Health Education England. Our condition is that these doctors should not be just used as a pair of hands to do the clinical work but must get proper training and pastoral care. To ensure this BAPIO has developed an International Fellowship Scheme and our team will be visiting India in November to interview doctors under this programme.

'Gods own country' Kerala has had devastating floods leading to tremendous destruction of properties and infrastructure. After completion of relief work, there is a daunting task of rebuilding damaged houses, social infrastructures and livelihood. BAPIO Charity would like to contribute to the massive rehabilitation efforts being undertaken and has set up a relief fund. Your contribution will be much appreciated.

The local organising committee has worked hard to ensure a very successful conference and deserve compliments. I congratulate Prof Parag Singhal and Mr Sanchit Mehendale for providing excellent leadership in coordinating the Conference preparations. Thanks to the Editorial team of Sushruta.

I hope you will enjoy the conference and I look forward to meeting and interacting with you.

Dr Ramesh Mehta OBE
President- BAPIO

Back to blame: Dr Hadiza Bawa-Garba could have been any specialty trainee.

JS Bamrah and Ramesh Mehta

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Introduction

The death of Jack Adcock in 2011 made headlines all around the world for many reasons. He was a 6 year old child, admitted to Leicester Royal Infirmary (LRI) in February 2011 who died of sepsis and pneumonia 11 hours later. The paediatric registrar Dr Hadiza Bawa-Garba had failed to diagnose his condition, resulting in criminal proceedings and her erasure from the medical register in 2017.

This article gives a glimpse of the controversial case, tries to relate this to all medical specialities and offers some guidance on how to avoid a similar situation developing.

Dr Bawa-Garba's background

Dr Bawa-Garba had dedicated her life to improving patient health from an early age. As a young student, from the age of thirteen she had volunteered in Africa. During her holidays, after school and at the weekends, she had worked at hospitals and AIDS clinics. She continued her charitable work as a medical student and later as a doctor by raising funds for benevolent causes and awareness of matters, mainly HIV/AIDS and organ donation. She used her unique position to provide necessary and effective health information to women in underprivileged communities.

She received a first-class degree in Physiology and Pharmacology from University of Southampton, where she also received the Physiology Society Prize and went onto study medicine, receiving outcomes of 'Merit' and 'Excellent' in many modules including in her finals. She continued to perform over and above average by contributing to excellent audit projects and guidelines, of high enough standard to be incorporated in working databases. She was popular with patients, families, nurses and fellow medics.

Dr Bawa-Garba

Events of 11th February 2011

On 11th February 2011, Jack was referred to LRI by his GP and admitted to a Children's Assessment Unit. He had a known heart condition and Down's syndrome. He presented with diarrhoea, vomiting and difficulty breathing.

He was treated by Dr Bawa-Garba, an ST5 specialist registrar. She had recently returned from maternity leave and was alone in charge of the emergency department and Children's Assessment Unit on the day. Rota gaps had meant that she had to cover the work of two other doctors and the on-call consultant was lecturing off-site and was unavailable to her.

She was in an unfamiliar setting, leading an inexperienced team, and covering the workload of three doctors (absent registrar and consultant, and her own role) as well as that of her SHO during the afternoon who was delegated to do telephone calls for results due to computer system breakdown. She was covering multiple areas, spanning four floors in the

Hospital, as well as being tasked with advice on paediatric patient matters external to her direct cover ward areas and to the wider community. The nursing team were also hard pressed to make full observations and due to pressures on beds patients were moved between ward areas and given medications without Dr Bawa-Garba's awareness.

Jack had a complex clinical picture. Even senior experienced doctors under treat severe sepsis in over 60 % of cases in the first twelve hours in the UK. She prescribed fluids, oxygen and antibiotics in line with guidelines and her initial treatment was acknowledged as good by the investigators of the case.
Jack died of a cardiac arrest as a result of sepsis at 9.20pm.

Legal proceedings:

On 2 November 2015, agency nurse Isabel Amaro was sentenced to a 2-year suspended jail sentence, having been found guilty of manslaughter by gross negligence. Her monitoring of Adcock's condition and record-keeping were criticised. She was subsequently struck off the nursing register. The ward sister Theresa Taylor was also charged but acquitted.

On 4 November 2015, Dr Bawa-Garba was found guilty of manslaughter by gross negligence. The following month, she was given a 2-year suspended jail sentence. She appealed against the sentence, but the appeal was denied in December 2016.
The Medical Practitioners Tribunal Service suspended Dr Bawa-Garba for 12 months on 13 June 2017. The General Medical Council's (GMC) successful appeal to the High Court resulted in her being struck off the medical register on 25 January 2018. There was national outrage and a tsunami of protests from doctors across the world to the case. A crowd funding campaign by 'Team Hadiza' ensued, resulting in over £350,000 being raised to support her in her fight against erasure. A separate legal team was appointed, and legal evidence was also submitted by BAPIO and the BMA as interested parties to the case.
The Master of the Rolls Sir Terence Etherton sat in judgement, along with Lord Chief Justice Lord Burnett and Lady Justice Rafferty1. In another twist to the tale, after the final hearing, he pronounced on the 13th August 2018 that the High Court had been "wrong to interfere with the decision of the tribunal." Sir Terence Etherton further stated that "The tribunal was an expert body entitled to reach all those conclusions, including the important factor weighing in favour of Dr Bawa-Garba that she is a competent and useful doctor, who presents no material continuing danger to the public, and can provide considerable

Co-author Dr JS Bamrah

IT failure, the Trust's paediatric observation priority score tool was not sufficiently robust or easy to interpret, test results were relayed by telephone but no abnormal results were flagged up, there was a failure by nursing staff to recognise abnormal observations and record and monitor according to clinical need, the Trust process for handover between medical and nursing staff was poor, and there was a failure to communicate to the child's family the importance of not giving enalapril.

Dr Bawa-Garba did commit a number of errors; principally, it was felt that the abnormal results should have been obvious to her, she had not alerted the on call consultant to them, she had misdiagnosed the condition, and she had mistaken Jack for another child and stated he was not for resuscitation when he had a cardiac arrest (though this was quickly recognised, and not attributed to his eventual death).
The Trust's SI report identified 93 failures, of which six were attributed to Dr Bawa-Garba.

The response from doctors:

There has been outrage amongst doctors and doctors' organisation about the final verdict to erase Dr Bawa-Garba from the register2.
7,500 doctors signed a petition sanctioning the GMC, and the BMA's GP committee passed a vote of 'no confidence' in the GMC.

Doctors attending the Royal College of Paediatrics and Child Health's AGM in Glasgow unanimously passed a motion stating: "This College considers [that] the criminal prosecution of dedicated doctors for gross negligence manslaughter, following systemic errors, impairs the advancement of safe healthcare for patients."

A group of 159 paediatricians wrote in The BMJ that they "are confident to employ Bawa-Garba with supervision in a training position upon her reinstatement to the medical register and pending her employment in a substantive post that will facilitate her return to work when she is reinstated."

The President of the Royal College of Physicians and Surgeons of Glasgow, David Galloway, stated: "I think that the profession has lost confidence in the General Medical Council. Doctors on the ground, especially younger doctors, are facing an overstretched service with sub optimal staffing that presents patient safety concerns. This is against the background of this tragic case and they, inevitably, feel exposed."

The BMJ stated: "We've received correspondence from readers

useful future service to society."
He instructed the GMC to restore her back on the medical register.

E-portfolios:

Since 2012, several concerns have been highlighted including in 2016, that for junior doctors "A large number of doctors are required to 'reflect' on Serious Incidents (SIs) and Significant Event information as part of their training. This could therefore create a significant administrative burden and result in cases of double jeopardy."
As required, Dr Bawa-Garba kept reflective learning material in an e-portfolio as part of her training, including relating to the treatment of Adcock. However, a major contentious issue that arose in this case was the use of this material, although to what degree has been disputed. Her defence team have stated that her e-portfolio was not used in the 2018 case. The contention amongst others is that although the e-portfolio was not used explicitly in the 2015 case, it had been seen by expert witnesses and so 'you cannot unsee what you have seen'. The GMC's own stance has been consistent, that doctors' reflections should be legally privileged.

Systemic failures:

A catalogue of clinical and administrative mishaps occurred on the day that Jack was admitted. Dr Bawa-Garba had just returned from maternity leave and did not have an induction which would have familiarised her with hospital procedures. There were rota gaps, an inexperienced nursing team,

around the world expressing their concerns about system failures, using e-portfolios in legal proceedings, and the threat to duty of candour."

Nick Ross, the journalist and TV pundit said: "I fear the time has come to hold the GMC to account. Can it show how this case has improved patient safety and standards in medicine, or - surely the only alternative - has it acted as an erudite and urbane kangaroo court?"

BAPIO accused the GMC of racial discrimination and victimising a trainee rather than understanding the pressures in the NHS. It called for the CPS to bring charges of corporate manslaughter on the Trust and referred the consultant on call that day, Dr Stephen O'Riordan, to the GMC and the Medical Council of Ireland for investigation of his conduct.

Most significantly, Jeremy Hunt, Secretary for State for Health, posted a tweet expressing concern about the unintended consequences of the verdict and launched a rapid review immediately, which is chaired by Professor Sir Norman Williams, ex-President of the Royal College of Surgeons (England). The review will make public its conclusions this summer.

Back to blame:

The real fear amongst doctors, and indeed other health professionals, following the conviction and erasure of Dr Bawa-Garba and nurse Amaldo is that genuine mistakes will be criminalised by the courts, thus jeopardising any learning from SIs. Furthermore, the likelihood is that many will be tempted to hide their mistakes rather than being candid, causing longer term harm to patients and the health service.

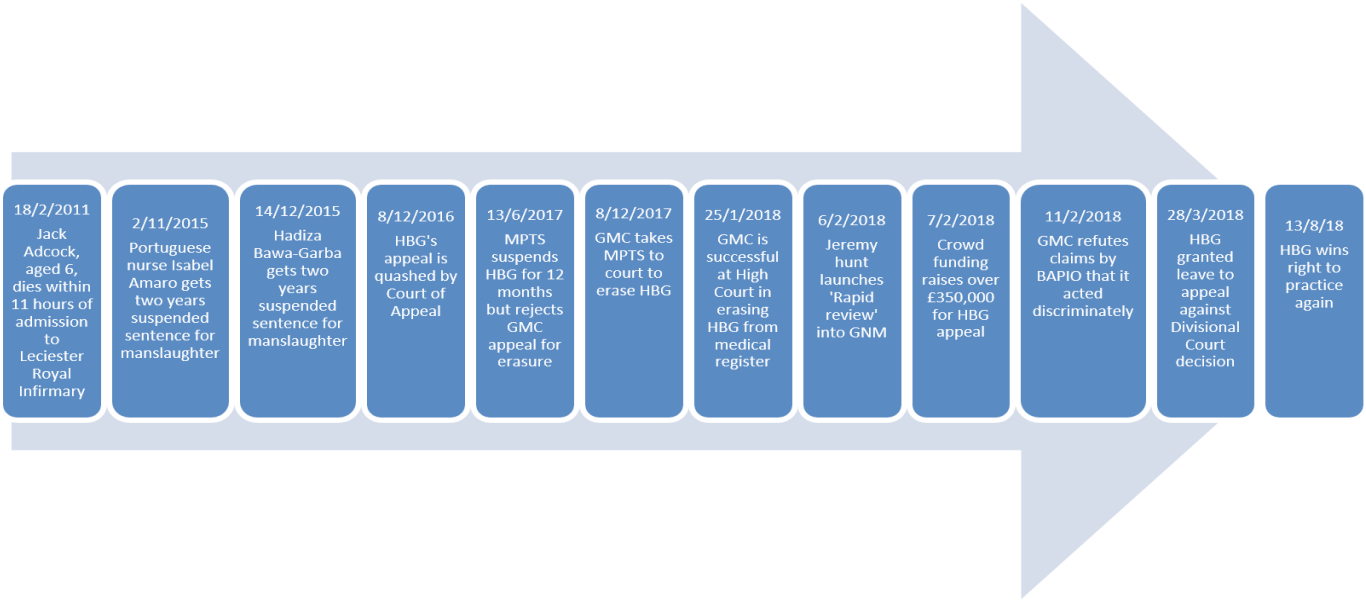
Amongst the most prominent critics are two individuals who in our view truly stand out both in regard to criticisms of the GMC's handling of the case.

Jenny Vaughan, a neurologist, the co-founder

'If Dr Bawa-Garba was white she wouldn't have landed in such deep trouble', said BAPIO

Speaking to GPonline, BAPIO president Dr Ramesh Mehta said: 'We are interested from the point of discrimination and equality. If Dr Bawa-Garba was white she wouldn't have landed in such deep trouble.
'Our submission will concentrate on worse outcomes for BME doctors referred to the GMC. Discrimination is an NHS-wide problem and institutional racism affects quality of care for patients.'

Time-line that shook the medical world



of an organisation 'Manslaughter and Healthcare' an online resource(www.manslaughterandhealthcare.org.uk), stated: "The GMC's actions here are purely punitive against a paediatrician who trusted the investigation process. It's terribly tragic that a child has died, but there are no winners in a system which blames tragic outcomes on a trainee. There was a catalogue of errors in this case, and patient safety will never be improved unless everyone promotes an open learning culture."

Jonathan Cusack, who supervised Dr Bawa-Garba and lead on a debriefing for staff affected by Jack's death, said that trainee doctors working in Leicester were concerned and angry about the conclusions of the trust's investigation and the subsequent legal process. "Trainees felt that their colleague was being scapegoated and taking the blame for a series of system failings," he said.

Implications for training – avoiding the pitfalls:

The first issue is that in the event that any doctor finds himself/herself struggling under the demands of pressure, it is vital that you call the senior manager responsible or, in the case of a trainee the consultant supervisor, to ensure that they have the support and advice they need to overcome any crisis or demand.

If essential, limit yourself to the emergency work that requires immediate action.

In the case of consultants who are on call, our advice is that they must give the trainee(s) on duty a call to ensure that they are made aware by them personally to call in the event of any issues. It offers a personal touch that cannot be achieved by simply having a name on the rota, which in some instances will be wrong anyway.

In the event of an SI, doctors would be advised to raise a DATIX entry on this, which will then generate a formal response from the Trust. Junior doctors must also additionally do Exception reporting to ensure that this event goes formally through the Guardian of Safe Working.

Portfolios are now under more scrutiny than ever, and until there is absolute clarity we would urgecaution in being absolutely candid about SIs. This is also true for appraisal documentation. The principle here is one that the insurance companies adopt, of not accepting any blame for an accident until the matter has been legally looked at. This is rather unfortunate but as it currently stands at the present time, all portfolios on paper or e-notes can potentially be used as evidence during trials.

The case demonstrates the need to have professional indemnity, and ensure that anyone affected is suitably supported. It threatens to change the course of medical history, with the prospect that genuine mistakes will be played out in court and punished in a criminal manner.

No specialty training is immune to this sort of event, particularly those that are patient-facing where risks are an everyday occurrence and the mixture of rota gaps, agency staff, multiple demands, poor IT back up are common. All those working in this crisis-ridden NHS must be aware at all times of the robustness of the system that they work in, or they risk facing similar consequences to Dr Bawa-Garba in the event of the death of a patient from mistakes that might have been made for genuine reasons.

Finally, trainees need to be aware that this is a highly unusual case and therefore it is unlikely, though sadly not impossible, for such a case to arise in the future. Ultimately, the public has faith that doctors act in good faith and so having the fear factor rule the practice of medicine is likely to cause more harm than good. Risk-taking remains part of perfecting the art of that practice and should rightly remain so for the future. Provided, of course, that safeguards are built into this.It remains to be seen whether the less discerning member of the public can differentiate between harm or neglect arising through wilful acts as opposed to honest mistakes.

References:
1. Hadiza Bawa-Garba vGeneral Medical Council.(2018) EWCA CIV 1879.www.judiciary.uk/judgments/bawa-garba-v-general-medical-council/.
2. BMJ coveragehttps://www.bmj.com/bawa-garba

The case for changing the narrative in health and social care

Prof Parag Singhal, MD, MPhil, FRCP, FACP
Organising Chair
Hon Secretary BAPIO
Chair BAPIO South West

With grateful thanks to Anand Kumar for his contribution.

"How can we all work towards changing the narrative and acting in different ways to make a difference to our patients, colleague and organisations alike."

Given our current challenges, how can we contribute to delivering more outcomes to make a difference to patient care and service efficiencies? In other words, how can we all work towards changing the narrative and acting in different ways to make a difference to our patients, colleagues and organisations alike.

Whilst not overstating the case, our NHS is being challenged from several angles. Many colleagues are under severe work pressures, are stressed, suffer with low morale, some are voting with their feet and many more are reporting burnout. And yes, some of our patients are not having the timely care that they deserve? Many of our organisations are in financial distress; some are in Special Measures and Turnaround Regimes.

The pressure points are being reported from several sources. For instance The Royal College of Physicians (2017) Survey Report NHS reality check: Delivering care under pressure involving 2,100 Doctors indicated that:

- 78% say demand for their service is rising.
- Over half of physicians believe patient safety has deteriorated.
- Over a third say the quality of care has lowered.
- 84% have experienced staffing shortages in their team.
- 82% believe the workforce is demoralised.

Prof Jane Dacre, President of the RCP, commented "I am sure these figures will not come as a surprise to anyone in the room. The physicians I know, and I include myself, are optimistic, positive, can-do people who produce 'workround' solutions to intransigent problems. However, they are being pushed to their limits and no longer are optimistic about the future."

Similarly the Guardian [11 Feb 2017] reported on a survey of 2,300 trainee anaesthetists and found that "six out of seven – 85% – are at risk of becoming burned out, despite only being in their 20s and 30s. Respondents identified long hours, fears about patient safety, the disruption of working night shifts and long commutes to their hospital as key reasons for their growing fatigue and disillusionment."

No doubt you may be able to point to similar findings and reports or know of colleagues with similar experiences. But here is the good news. Yes, we are pressured and face many challenges, but we are not and should not be helpless. Several commentators have argued that staff at the front line knows the solutions. I believe the time is right for us all to play our part in helping to change the narrative and as a consequence act differently. It is time that we build on the massive good will of most of our colleagues and it is time to liberate energies and mobilise collectively to add value.

So what do I mean by "narrative?". Collins English Dictionary defines a narrative as "a story or an account of a series of events." All of us and leaders at all levels need to change the narrative by effectively sharing stories that can engage and mobilise others to action.

Steve Denning is a leadership thought leader, author and guru. A short while ago, a colleague asked him why leadership story telling was important. He came up with a long list. I am including 2 accounts here.

- Storytelling is a key leadership technique because it's quick, powerful, free, natural, refreshing, energising, collaborative, persuasive, holistic, entertaining, moving, memorable and authentic. Stories help us make sense of organisations.

- Storytelling can inspire people to act in unfamiliar, and often unwelcome, ways. Mind-numbing

cascades of numbers or daze-inducing PowerPoint slides won't achieve this goal. Even logical arguments for making the needed changes usually won't do the trick. But effective storytelling often does.

We know that there are different types of stories and Steve Denning has shown how stories can:

1. Spark action (the original springboard story)
2. Communicate who we are (identity stories)
3. Communicate who the company is (corporate identity and branding)
4. Proclaim and transmit values (value stories)
5. Foster collaboration (community-building stories)
6. Tame the grapevine (political stories)
7. Share knowledge (tacit knowledge stories)
8. Lead people into the future (inspirational and vision stories)

Similarly, Dr Helen Bevan, Chief Transformation Officer, at Horizons NHS has been at the forefront of promoting the work of Prof Marshall Ganz from Harvard whose work on the power of stories for creating change and mobilising for action offers great potential in the NHS. Prof Ganz has argued that "Stories not only teach us how to act – they inspire us to act. Stories communicate our values through the language of the heart, our emotions. And it is what we feel – our hopes, our cares, our obligations – not simply what we know that can inspire us with the courage to act."

Prof Ganz has proposed that a public story includes three elements as follows:

- A story of self: why you were called to what you have been called to.
- A story of us: what your constituency, community, organization has been called to its shared purposes, goals, vision.
- A story of now: the challenge this community now faces, the choices it must make, and the hope to which "we" can aspire.

Story telling from board level all the way down to the front line is vital at engaging and mobilising all of our people for sustaining action that can bring about a better patient and staff oriented NHS. They can serve to develop better collaboration within and across organisations as well as laying the basis for delivering on efficiencies and productivity. It can help to create a work climate that enables us to be more caring, supportive and compassionate to our colleagues.

Some encouraging signs:

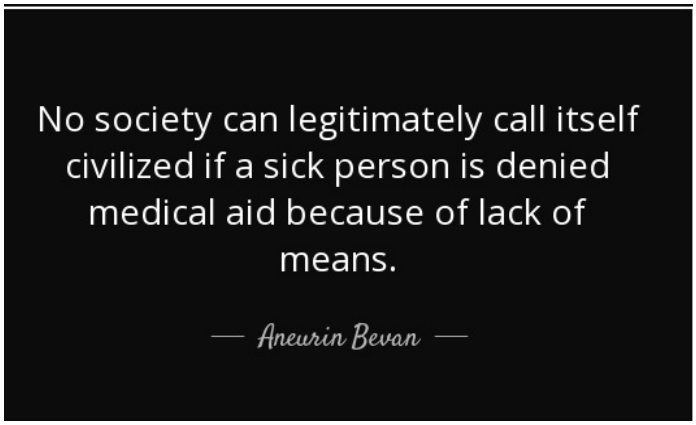
The good news is that there are some encouraging signs in which Clinicians, Leaders and Managers are stepping up at taking a lead on changing the narrative. Writing in BMJ (BMJ 2017;359:j4304), Dr David Oliver has argued why it is useful for Challenging the victim narrative about NHS doctors BMJ 2017; 359.

Despite the challenges being faced, he has suggested that doctors "are not hapless victims. We have to be realistic as to what we can achieve. We must also use our considerable hard power, soft influence, and status to the best effect to preserve and improve patient care."

On similar lines, a recent tweet from Mr Ross Fisher, a paediatric surgeon at Sheffield Children's Hospital "I'm the Consultant on call today. I gathered the whole team together and reiterated that we work as a team, that mine is the ultimate responsibility, that if they have concerns they escalate and NO-ONE gets thrown under the bus.

These are the kinds of narratives and stories that lead to action, which needs no one's permission. Imagine then the work place culture if more and more Consultants were to take a lead from Mr Fisher's example?

2018 marks the 70th anniversary of the establishment of the NHS. It is a time to celebrate the wondrous achievements of the service. It is also a time to make a Call to Action, given our challenges, to invite everyone to play their part in the making of a sustainable NHS. Our starting point is to change the narrative to build a service that will benefit patients and staff.



The BAPIO SW Leadership Initiatives – *Creating a novel and effective force!*

Dr Uma Gordan, Consultant Gynaecologist and Clinical Senior Lecture, University of Bristol
Dr Dharam Basude. Consultant Paediatric Gastroenterologist, UH Bristol NHS FT
Dr Mangla Mundasad, Consultant Psychiatrist, Bristol

Since its inception in 1948, NHS has gone through major organisational changes. It is clear that the Leadership models of even the larger companies are unlikely to successfully cater to the vastly varied needs of the NHS. Sir Francis report highlighted poor leadership styles and provided a new impetus and urgency to resolve this matter.


Dr Uma Gordon

Therefore, in recent years, there has been significant investment in Leadership development programmes by Department of Health and NHS England. Leadership is not a one-off achievement for an individual but a progression of skills. There is also a clear argument that effective change requires good Leadership at all levels with similar overall goal. There is far less representation of black and minority ethnic staff at board or senior leadership positions in the NHS.


Dr Dharma Basude

It is also clear that Clinical Leadership is most likely to allow the understanding of the needs of NHS and steer the direction of change. However, many key issues in NHS are not just limited to specialities but also across many NHS Trusts within the region or even the nation. There is an urgent and compelling need for Leadership that reaches across the boundaries of organisations providing important aspect of collective leadership. There are not many models for collective leadership in NHS and this is even more important within a region where there are likely to be significant interdependencies and solutions that are applicable across the NHS trusts. But to make this possible, one requires a forum for the leaders to meet without these organisational boundaries and resistance of bureaucracy or politics aiming to improve the overall patient care.


Dr Mangla Mundasad

BAPIO South West and OurNHSOurConcern is leading the way under the leadership of Prof Parag Singhal in bringing the leaders together from today and tomorrow in a unique way in driving the agenda for change. BAPIO South West has so far brought together, both clinical and non-clinical leaders , from at least 6 different trusts within the region.

Leadership Programmes:

'Leadership is a journey and not a destination'. With this in mind, locally we run a 4 monthly programme under the leadership of the core committee. The format is interactive, with brief talks setting the scene followed by plenty of opportunity and motivation for open discussion. This is followed by small group work to identify practical, sustainable solutions, which can be implemented in local units. Facilitating positive discussion with learning from each other's experience creates a fulfilling experience and provides satisfaction of working out real and practical solutions without organisational boundaries. The topics identified so far are active issues affecting us all such as reducing demand, improving productivity within economic constraints, staff motivation, patient safety, understanding human factors in NHS, quality improvement and effective transformation with clear local examples and analysis of successful programmes.

BAPIO Highlight:

South West BAPIO members met His Excellency Mr Sinha, High Commissioner of India on the 4th of May 2018, during his visit to Bristol, the first in 26 years. The aim of the visit was to strengthen business and academic relations between the two countries. The Lord Lieutenant of Bristol Mrs Peaches Golding OBE

welcomed the HC and oversaw the arrangements to visit the Universities of Bath and Bristol and their students. He also met Business leaders at breakfast including the Metro Mayor Tim Bowels and later BAPIO Members at a tea party at City hall. This was followed by the reception hosted by Prof. Brady, VC of University of Bristol. The visit has opened the doors for academic exchange in areas of mutual interest for both countries and follow up visits and meetings are being arranged.

Our South-West community is grateful to Prof. Parag Singhal, Chair SW BAPIO and Mr Stephen Parsons, Deputy Lord Lt for organising this visit.

Dr Ramesh Mehta OBE With Rt Hon John Penrose MP, Dr Mohan Mundasad, then Deputy High Commissioner Dr Virander Paul, Prof Parag Singhal

The Vice Chancellor of the University of Bristol Hugh Brady and Daren Jones MP the Labour MP (Bristol North West) speaking at the dinner at the Royal Fort in honour of the High Commissioner

Conference organisers of the day
Professor Dr Parag Singhal and Stephen Parsons
with the High Commissioner

Remembrance for Dr Raja Ram Mohan Roy

Sir Malcolm John Grant, CBE,
Chairman of NHS England

Mr Mark Cooke
Director of Commissioning

Lord Ajay Kumar Kakkar,
Professor of Surgery

National Conference on Women Leadership

BAPIO has also made headway in promoting Women Leadership through a conference, which was very successful in motivating and empowering women. Many esteemed women, who had achieved the highest positions in their respective fields, were in attendance, as speakers and delegates. It was inspiring to listen to these women leaders elaborate on the challenges and hurdles they encountered through their journey to rise to the top.

Although titled as Women Leadership conference, it was equally attended by many men, who offered valuable contribution to the discussions. There was a blend of high-level speakers, managers, middle grade and junior doctors as well as medical students. Talks ranged from value-based leadership to work-life balance, breaking stereotypes to the role of a mentor. The BAPIO SW in my view is leading the way in creating and nurturing a force of leaders who can make a real change not just within their departments, but their organisation, region and hopefully at a national stage.❑

Quality improvement in NHS

Dr Sahana Rao
Consultant Paediatrician,
Oxford University Hospitals NHS trust

Quality improvement (QI) is an integral part of providing high quality patient care. Any discussion about affordable NHS care cannot be complete without an affirmation to QI, which needs to be a key priority. The resources in any health care setting including NHS are finite. In a changing medical landscape; while dealing with an increasing patient population; complex medical co-morbidities; ageing population and changing patient expectations, it is vital that we strive to continually use QI to improve our services.

What is QI?

Quality improvement has been defined in various ways:
"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"
(US Institute of medicine).

"The combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, payers, planners and educators- to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)"(Paul Batalden and Frank Davidoff (BMJ Quality & Safety 2007;16:2-3.)

Why do we need to get involved with QI?
Safe, Timely, Effective, Efficient, equitable and person-centred care are the six universal dimensions of healthcare quality. QI is essential for teams to ensure that patients get the right care in the right place at the right time, every time and improve efficiency of services.

It is a key component of medical revalidation and GMC Good Medical Practice suggests that, "You

must take steps to monitor and improve the quality of your work (13, Domain 1) and Contribute to and comply with systems to protect patients and you must take part in systems of quality assurance and quality improvement to promote patient safety. (22, Domain 2: Safety and quality).

Starting with QI: QI methods and tools

A systematic narrative review of QI models in healthcare (Powell et al, NHS Quality Improvement Scotland, 2009) concluded that "there is no one right method or approach that emerges above the others as the most effective".

Initiating change:

The model for improvement provides a framework for developing, testing and implementing changes by answering the 3 key questions:

1. What are we trying to accomplish (aim)
2. How will we know a change is an improvement (measurement)
3. What changes we can make that will result in improvement.

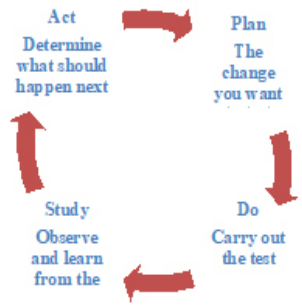
Some methods to do this include root cause analysis; 5 whys; process mapping; trigger tools; mapping patient journey and patient & staff experience data.

Stakeholder engagement:

Inspiring shared purpose and leading a team through a QI project can be challenging at times and having a team of resilient, passionate and committed enthusiasts is a battle half won. Patients, service users and their friends can make significant contributions to quality improvement projects by combining their perspective and expertise with those of staff involved in a service leading to robust and realistic proposals for change.

Implementing change:

The Plan Do Study Act (PDSA) is a popular method for implementing change.



PDSA helps accelerate improvement by undertaking small, frequent cycles. It is an excellent way to test change by taking ideas; trying them in practice and learning from mistakes. It is safer; less disruptive and involves less time, money and risks. By testing early and often, we can identify the theories/assumptions; help avoid the confirmation trap and lead to effective innovation and better results.

Measurement of change

Assessment and measurement are essential in QI. The data collected prior to the introduction of change can provide evidence that improvement is feasible. Regular measurements throughout the project will reveal if the QI work leads to the desired outcomes and if these improvements are sustained.

Measurement can be both qualitative and quantitative. Outcome measures reveal the impact on patients; process measures reflect the systems, pathways and processes involved and balancing measures reflect the impact of the change on other areas. Run chart is an effective tool to collect, review and analyse the data. Small amounts of data are collected regularly and compiled into 'runcharts' provides a pictographic representation of the impact of change over time.

Sustainability of a QI project:

Irrespective of whether positive changes are achieved or not; it is essential to share the learning widely so that others can adopt it. There should be formalised processes in place to ensure the improvement is embedded into routine practice and sustained with governance arrangements.

The future:

The frontline NHS staff have an excellent understanding of the challenges in NHS and are motivated to lead change. Junior doctors are expected to undertake QI projects as part of their training and though motivated to participate in a high quality project; they may lack the skills to maximise the effectiveness. Formal support for developing quality improvement skills is often difficult to access and as a result quality improvement projects can be seen as a 'tick-box' exercise. In Oxford, we provide a comprehensive programme for QI in paediatrics with the QI teaching sessions; peer mentoring and resources to undertake QI projects. It is upto us to support our teams; equip them with the skills to channel their ideas; passion and enthusiasm and guide the next generation of NHS. ❑

Children with Acquired Brain Injury (ABI) - *What do we owe them?*

Dr Daphin Fernandez
Consultant Paediatrician with neurology interest
Bristol Royal Hospital for Children

Traumatic brain injuries following road traffic accidents, stroke, brain tumour and its treatment constitute a large proportion of children with acquired brain injury (ABI).

There are at least 35,000 children being admitted due to traumatic acquired brain injury (ABI) annually in the UK [(1)]. It is estimated that about 82.3 children per 100000 are affected due to non-traumatic ABI.

Recent advances in criticalcare including out of hospital care, neurosurgical and neuroprotective strategies and oncological management have resulted in improved survival in children with ABI. The focus of attention is gradually shifting from improving survival to improving quality of life for children with ABI. The impact and morbidity due to ABI is substantial not only to the individual child but to the affected family and the society as a whole. Gordon et al [(2)] have demonstrated that there is an increased prevalence of prior traumatic ABI in juvenile prison inmates studied in Texas county of US. This indicates a huge vulnerability of children following ABI to get involved in criminal behaviour. Given that brain injury can affect the networks that regulate emotions and behaviour, it is not a surprise that mental health difficulties are common following ABI. Affected children develop functional difficulties in various domains including mobility, dexterity, memory, processing speed, attention, concentration, emotion and behaviour.

Often following traumatic ABI motor function recovers well in children and they appear normal. This can often create a false sense of normality and children not infrequently get labeled as naughty or lazy in school when they fail to perform as expected. This invisible injury results in conflicts with school including behavioural issues and can easily spiral into school failure if not intervened in a timely fashion. The increased stress of trying to cope with the societal expectations with an altered brain function can push quite a few youngsters into clinical depression and anxiety disorder. While children with preexisting attention deficit hyperactivity disorders (ADHD) are more likely to be involved in traumatic ABI, it has been shown that even 5 to 10 years later, children with ABI can also develop ADHD [(3)]. Together, all these difficulties lead to poor societal participation and achievement in life and a poor quality of life as a consequence.

Neurorehabilitation is defined as a goal directed process aimed at reducing the impact of disabling brain and spinal cord injury (NHS England). It is a concept and a principle that in practice should start as soon as the acute medical and surgical interventions start following an ABI. The process of neurorehabilitation should then not only continue during inpatient hospital stay but also should follow the child into the community, enabling their effective reintegration in the community.

In the UK, It is only in the last decade that paediatric neurorehabilitation is being gradually recognised as a service and only in 2014 did NHS England come up with a service specification and specialist commissioning agreement for paediatric neurorehabilitation. Thus, for the south west of UK, Bristol Royal Hospital for children (BRHC) neurorehabilitation team provides the tertiary neurorehabilitation services for children following ABI. It is a multidisciplinary team comprised of a paediatric neurologist, paediatrician with neurology interest, neuropsychologist, physiotherapist, occupational therapist, speech and language therapist, dietician, discharge coordinator, hospital school, play specialists, music therapist, nursing staff, junior doctors and child brain injury trust (CBIT) representative.

There is still a poor understanding of the needs of children with ABI in the community and consequently services in the community are not uniformly geared to meet the needs of children with ABI. There is an urgent need for educating and establishing neurorehabilitation services in the community for these children with ABI. This can be partly achieved by having a managed clinical network for paediatric neurorehabilitation, a kind of which has recently become operational in the southwest now. There is also a vision for establishing an outreach service from the specialist tertiary centre into the community. With political commitment and appropriate interdisciplinary working by Health, Education and Social services it is possible to allow children with ABI to achieve their potential and thus fulfill their rights[(4)]and we owe this to them.

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2. The relationship between traumatic brain injury and criminality in juvenile offenders. Gordon WA et.al. J HeadtraumaRehabil. 2017 Nov/Dec;32(6);393-403.
3. Secondary Attention deficit hyperactivity disorder in children and adolescents 5 to 10 years after traumatic brain injury. Nara ME et.al. JAMA paediatr.2018;172(5):437-443
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Conflict of interest: I am part of the paediatric neurorehabilitation team at Bristol Royal Hospital for children.

Beyond BAWA-GARBA:
We deserve better

The medical profession is in crisis and working in a climate of 'toxic fear', according to the chair of the gross negligence manslaughter review commissioned by the GMC following the Bawa-Garba case. Dr Leslie Hamilton, who replaced Dame Clare Marx as chair of the independent review in July, warned that health leaders had a lot of work to do to regain doctors' trust.

Authors: Prof Parag Singhal; National Secretary of BAPIO. and Buddhdev Pandya MBE; Chief Executive of GAPIO Europe and Director British Indian Psychiatric Association, Former Director International Doctors Association and former Director of Governance and Policy of BAPIO.

They say that the recent case of Dr Bawa-Garba became a 'lightning rod', shaking the medical fraternity of the NHS and its regulatory authorities.

It exposed inherited system failures and the chaotic style of managing the health service and its professionals.

The endemic system failures are often hidden behind a cloak of argument of 'lack of funds' while on the surface the reports of Sir Robert Francis have exposed wastage through a culture of bad planning.

In his report relating to the Mid Staffordshire NHS Foundation Trust Public Inquiry to the Secretary of State for Health in February 2013, Sir Francis had highlighted one of the issues that is central to accountabilities and good practices is governance.

He wrote, "The story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention.

Furthermore, he pointed out, "Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care".

Now in the year 2018, Dr Leslie Hamilton, Chair of the independent review panel into gross negligence manslaughter, and culpable homicide again warned, "The medical profession is in crisis and working in a climate of 'toxic fear' and that the health leaders had a lot of work to do to regain doctors' trust."

The medical professionals are busy trying to point out what had gone wrong in the case of Dr Bawa-Garba and hoping to pin the blame on a single or many causes of failings in the system.

The truth is that beside severe financial constraints, the culprit is the lack of accountability and ability to plan and implement sound, strategic management policies by most of the NHS Trusts. Most front-line workers, from consultants to the trainee doctors would have a story to tell that vindicates the claim.

These bodies have members of Executive boards largely dependent upon the expertise of their most senior officers; Chief Executive, Medical Director and the Head of Human Resources, management supported by a plethora of private sector advisors, consultants and administrative teams.

The tail chasing exercises for some proves a 'gravy train' promoted with slogans associated with new initiatives which adds very little to patient safety or outcomes, except additional burden on the middle grades and juniors, pushing them to the verge of risking their state of mental health. But in the medical fraternity, it would be considered 'harsh' or 'negative' criticisms of the system!

It does not mean that there are no voices raised against

what is wrong in every hospital without offering some form of practical and workable simple solutions by the people who live and work in and environment of fear of victimisation. Even, dreading the potential to be isolated or put on the journey of hell through 'disciplinary' process for issues that has little to do with patient safety.

The regulatory bodies such as the CQC seem to have been ill equipped to provide an independent candid exposure to the state of our NHS providers. It is doubtful, if their structures are weaker by design or default to pin point 'failures' both at the planning and implementation levels to hold the most senior officials and the executive board accountable.

Even though, giving benefit of doubts, if reports succeed to highlight shortfalls, it is usually a tip of the ice-berg and reflects very thinly the experiences of the work-force. To put it bluntly, if this was not the case, Dr Bawa-Garba would not have experienced the environment of abandonment during her service.

It is not an exaggeration to say that given the neglect of care that the executive boards should have been providing; both by identifying hotspots and proactively making efforts to redress the pitfalls, more Bawa-Garba are waiting to happen in the future.

Unfortunately, there are no defined mechanisms or even sanctions under the structure of accountability that can hold the Board of executives to account.

The liability virtually dissolves under a cloud of formal apologies or compassions paid out of the NHS budget, but not yet seen a proactive intervention from the level of the Secretary of State to take away the powers to govern or appoint a team of experts to replace the Board members of the NHS Trust that fails to provide safer environment for workers as well as the patients.

At best the confusion and chaos that exist are defended with an excuse of lack of funds. It keeps activists fully occupied in chasing a mirage. Few independent inquiries specific to a subject matter are announced or a part funding is allocated to win brownie points. The patch work and knee jerk reactions changes with political climate and Ministers without any strategic shift in the way the NHS is run.

While we have to bear the pain and distress, the NHS is marking its 70th Anniversary. There are no quick fixes but a hope of pushing the government to pour more funds to act as sticking plaster when a major holistic look at the NHS is required.

What is needed is a comprehensive and thorough review encompassing the past seven decades of service, reflecting on the service delivery structures, as well as the regulatory and monitoring regimes, in order to suggest opportunities for the improving management structures that are more effective and efficient. Consolidating experience of seven decades could enhance ways of implementation processes that have better accountability with identifiable hot sports of lapses to be fixed.

Most importantly, integration of modern technology and establishing boundaries of the private sector engagement with the public sector to preserve what was the original ethos of the NHS when established seventy years ago. A royal Commission on the NHS is the need of the hour. It would allow politicians, professionals and users to align with other stake holders to feed in their expertise, recommendations and vision. It may provide an independent and honest broker, away from the party-political tug war to build a consensus.

The fate of the medical professions is tied up with the way the regulatory bodies operate the process of licences to practice. If not the GMC, there would be another body in its place and we just can't wish it way.

Almost everyone in the medical sector shares a common view that GMC is in a desperate need for reforms to replace outdated, cumbersome and inflexible legislation to provide with streamline processes to deliver model regulatory structures for improving confidence in the medical profession.

The GMC should be the first to warn the failing NHS Trust in obligation to provide safer environment for the medical professional – that it would withhold the permission for training, if the concerns are not suitably addressed.

The beast needs to tackle the culture of bias; conscious and sub-conscious or institutional, that impact the career of many international medical graduates. It is an affront to human dignity and justice.

Even the Bow Group has noted and there is ample evidence available that the overseas and ethnic minority doctors are more likely to be struck off and that this shapes the public's view. It has called for urgently examination by Parliament to consider amendments to the Medical Act.

In conclusion, we need to lobby people in public life and politicians to influence for initiating two major comprehensive reviews; the reforms of the NHS and GMC. ❑

In pursuit of Sun, Solitude and Self - Trek to the Everest Base camp

Dr Guru Karnati
Consultant Radiologist
Taunton and Somerset NHS Foundation Trust

This whole crazy journey started while I was watching a music video with the Himalayas in it. This sparked something crazy in me. Instead of sitting there behind a screen, I wanted to be there in person. The idea to trek to the Everest Base camp was now born.

After I realised I truly wanted to do this, I immediately shared my crazy idea with a few who I reckoned would be equally crazy. What started as a casual suggestion, solidified and eventually turned into an expedition, set for April 2018. Out of the fifteen people with potential interest, it wilted down to just four.

I along with Dr Sathish Williams (GUM consultant, Taunton), Dr Sorna Kumar (Dentist, Plymouth), Dr Gopinath Selvaraj (Anaesthetist , Carmarthen) became the expedition team.

Once the initial excitement settled, we were faced with the reality of addressing the challenges that came along with hiking 130km and climbing 5500m in altitude. This then lead to searching for a reliable trek company and gathering options on when and how to get there.

We all had to start training to ensure we were prepared for the journey ahead. Personally, I started to walk everywhere and even climbed the multi-storey car park at my hospital twice a day, totalling 360 steps. This also included daily training, weekend long walks, hill climbs and many trips to the highest peak in the South West, Pen-y-Fan, Brecon Beacons, Wales.

The most recognisable and famous sign post

One of these trips coincided with the worst weather the country has experienced in recent times, including the worst blizzards since 1962. Despite the harsh weather we still continued the trek as per plan. It may have been a shortsighted decision at the time, but in the end, this gave us courage and experience to face any serious conditions.

The four of us then embarked on this once in a lifetime journey to the Everest base camp in April 2018. The trek itself was 12 days of approximately 5-6 hours of walking every day with a couple of acclimatisation days in between. We had Chandra, our guide and two porters to help us complete the trek. The first challenge to overcome was the scary experience of sitting through the short flight from Kathmandu to Lukla, one of the most dangerous airstrips in the world. Unfortunately or rather fortunately, our flights got cancelled due to bad weather and we flew by helicopter instead. However this offered us unparalleled views and a new experience.

We then arrived at our first tea house, a small bed-and-breakfast-like hotel which are dotted along most of the treks in the region. The food menu had a wide range of options and I ordered the much-awaited "mo-mos" which were absolutely delicious.
The typical tea house provides all the basic amenities needed to trek in the Himalayas such as beds, a hot meal and the option of a hot shower.

This is also the chance to meet the local people, who were very accommodating and friendly and also to meet fellow trekkers.

We then commenced onto our first day of trekking, a

short and easy 3-4 hour walk to Phakding village for the overnight stop. On the second day we continued up to NamcheBaazar where we experienced heights of 3000m, the magic number for altitude sickness.

The trek took us along the banks of the DudhKosi which we crossed by small suspension bridges. The swing of the bridges, the dizzying heights, the cold winds, the oncoming traffic of humans and yaks, the sound of the river and the breath-taking scenery, all combined to provide an indescribable feeling of exhilarating experience.

We then reached the village of Monjo the entrance gate of the Sagarmatha National Park.

Unfortunately, one of our mates developed altitude sickness at Namche Bazaar, a beautiful scenic town at an altitude of 3440m. Despite immediate medical attention and an extra day for acclimatisation, he had to be shifted back to Kathmandu for further medical attention.

After sorting out the logistics of his transfer, the three of us continued ahead. On day three of the trek, we had the first sighting of Mt Everest peak. The great view of the mighty peaks of Everest, Nuptse, Lhotse,AmaDablam, Thamserku and Kwangde peak with view of the eastern snowcapped mountains were breath taking. The trail leads us up hill through the forested path and a hard walk to get to Tyangboche, housing thelargest Monastery in the Khumbu region.

The following days we were steadily gaining in altitude and conditions got tougher and progressively challenging. The next day, we started our trail to Dingboche (4,358m/14,295 ft), 5-6 hrs walk, winding through the rhododendron forest to Deboche and crossing a bridge over the raging ImjaKhol River. We moved out of Dingboche on Day 7 and headed for Lobuche on the final stretch to Everest Base Camp, up the famous Dugla hill and at the top of the cemetery for lost climbers, a sombre place, with stunning scenery back across the valley and jagged peaks jutting out across the skyline.

The pace was gradually getting slower, but everyone was still doing good and we kept talking to each other and pushing ourselves. The mountain, the team, the support, the guides, the training all working to get us to our goal and we were having the time of our life.

Motivated to move on to our final destination of Everest Base Camp we started early the next day and moved alongside the Khumbu glacier which kept us company all the way to Base Camp. We stopped for a break at Gorak Shep to get ready for the final leg of our mission. At 5,160m/16,929ft, the air is really thin and the week-long trek had taken a toll on the body and the legs were feeling dead and heavy. However, the excitement of being so close to our mission and realising our dream pushed us along.

Even talking to each other became an arduous task at this stage. It took us three hours to complete the trail that took us over rocky dunes and moraine and streams. Finally, we made it. We were at the Everest Base Camp. It felt surreal standing in front of the colourful tents of the summiteers, walking on the ice at the bottom of the ice-fall and this was a dream come true. What a moment and one I will never forget. We spent an hour walking and talking and headed back to Gorak Shep for the night.

L-R - Nooru (Helper), Dr Sathish Williams, Dr Guru Karnati, Chandra (Guide) Farkey (Helper) and Dr Gopinath Selvaraj

Egged by our base camp success, two of us decided to wake up at 4am for our Kala Patthar summit in the morning. This small peak offers the best views of Mt. Everest, Nuptse, Pumori and Ama Dablam along with the entire mountain views of Khumbu Himalayan range and we also can see the Everest base camp. The Kala Patthar climb was one of the most grueling 2 hours I had ever experienced in my life.

Sunrise view of Mt Everest from Kala pathar (3555m)

As one of my good mates summed it up, starting at 4am in the morning, pitch black surrounding, treacherous mountain, icy wind, no air to breath, tired legs after a week trek, far away from loved ones, no proper food and amenities and many more. You are not conquering the mountain but just conquering yourself.

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BAPIO's Written Submission to the Williams' Review

BME doctors: The state of bias in the NHS and impact of differential sanctions by the GMC
Written Submission to the Williams' review

"A doctor is one upon whom we set our hopes when ill and our dogs when well"
William Carlos Williams, American poet and paediatrician

The NHS and racial discrimination

The majority of doctors registered to practice in the U.K. work within the National Health Service (NHS). In 2017 there were 236,732 doctors on the General Medical Council (GMC) license to practice register, comprising 74,055 Specialists, 59,598 General Practitioners (GPs), 42,631 doctors who not on the specialist register or in training (usually called Specialty and Associate Specialist doctors) and 59,194 trainee doctors.

The NHS is heavily reliant on doctors who have qualified overseas, so that a substantial number of all grades of doctors are from a Black and Minority Ethnic (BME) background. Including doctors qualified in the UK, almost 41% in England are BME, with regional variations so that, for example, in the South West of England 18% are BME while the West Midlands has the highest proportion (52%). Across other countries in the U.K. there is a lower preponderance of BME doctors, with Wales having 33%, Scotland 19% and Northern Ireland only 9% of doctors from a non-white background. Unlike other countries in the U.K., Northern Ireland has a high rate of 'keeping its own' with only 14% of its medical workforce deriving their primary medical qualifications from overseas.

Recommendations

Recommendation 1: The review must advise the GMC and the NHS to acknowledge the existence and impact of racial discrimination and make concerted efforts to improve this image nationally and abroad.

Recommendation 2: The review panel must recommend to the NHS that training in Equality and Diversity is fit for purpose and not a cursory online package. BAPIO would be willing partners with NHS England and other organisations in devising a competent training programme.

Recommendation 3: BAPIO recommends that the GMC urgently reviews the function of MPTS, and we would further recommend that the GMC must lose its authority to overrule its verdict and take a case to the High Court.

Recommendation 4: The panel must invite the GMC to provide assurance that its processes are subjected to Equality Impact assessments and that action plans are drawn to ensure fairness.

Recommendation 5: BAPIO recommends that in the event that the panel cannot accede to our demand to remove that GMC's decision to overturn the decision of MPTS then any such decision must be vetted and agreed by an external panel independent of the GMC.

Recommendation 6: BAPIO recommends the setting up of a combined unit with the CPS and the police, which must investigate all charges of GNM.

Recommendation 7: Such a panel, or in the absence of this the CPS, must compile a register of all cases of GNM so that this is available for audit purposes and any learning that might be derived from this.

Recommendation 8: BAPIO also recommends that any case of GNM must not be dealt with in isolation, and therefore our expectation is that in all cases systemic failures must be considered and healthcare providers, where relevant, are investigated under the Corporate Manslaughter and Homicide Act 2007.

Recommendation 9: Reflections and appraisals must be considered legally privileged and must not be submitted as evidence in GNM trials.

Summary

BAPIO welcomes the Secretary of State for Health's review of GNM. There has been widespread concern about the injustice in the Dr Hadiza Bawa-Garba case and other cases of GNM so there is an urgent requirement to ensure that there are significant improvements to a system that is seen by our members as discriminatory, within the judiciary and particularly at the GMC. It is vital that the medical profession commands confidence in its regulatory body, and we hope that our recommendations, if met, will go some way to creating a more just, equitable and proportionate system which is safer for the patients, and supportive for doctors of all origins.

THE INDIAN HEALTHCARE SECTOR

Buddhdev Pandya MBE
CEO- GAPIO EUROPE

Comparison with the British National Health service:

When the National Health Service (NHS) was launched on July 5th, 1948 by the then Minister of Health, Aneurin Bevan, it was founded on the ideal that good healthcare should be available to all, regardless of wealth.

It has three core principles embodied in the shaping of services; it meets the needs of everyone, it is available free at the point of delivery and based on clinical need – from cradle to grave, not ability to pay. It was to be fully funded through public funds with limited use of the private sector.

In contrast, in India, the private sector, which includes service providers and pharmaceutical companies, has the largest influence on India's 'Health Care' policies. Last year alone the interest from private equity funds in the healthcare industry in India was projected to reach $155 billion in terms of revenues (Source: LSI Financial Services). A senior doctor in the Bhartiya Janata Party, described India's private healthcare sector which "treats patients as revenue generators" (February 24, 2015). There are genuine fears that the private healthcare providers in India seem to be "above the law, leaving patients without protection."

In relation to the argument of creating an 'inclusive society' that can be viewed somewhat parallel to the British NHS, the Indian government spends around 1.3% of its GDP on healthcare, much lower than the global average of 6%. The Indian Medical Association (IMA) has demanded that it be increased to 5% as per the recommendations of an inter-ministerial committee. The government is failing to provide primary and secondary medical care as 80% of this is provided by the private sector; 70% by small hospitals and private doctors. The present administration has made the private sector its main 'mascot' for health care policy drivers, perhaps recognising the potential of capitalising on the multi-billion 'health care and wellbeing' industry across the globe.

India has a massive legacy of the use of traditional remedies such as Ayurvedic medicine ("Ayurveda" for short). It is one of the world's oldest holistic ("whole-body") healing systems, developed more than 3,000 years ago in India. There are also other similar medical streams that impact upon the culture of the population in the context of creating uniformity in the health care sector across the nation. These practices are not optional and form an integral part of the healthcare landscape that exists in India. There are many international companies that are engaged in exploiting valuable properties in plants and other natural elements in order to repackage them as modern medicine and securing trademarks. The incumbent administration has invested in developing Ayurvedic and Homeopathic medicine as major pillars of its strategy and its integration with the mainstream medical diagnostic and treatment processes.

Many areas of concern have been raised against the proposed National Medical Commission (NMC) Bill, 2017; the most troubling of them are the clauses which approve a "bridge course" for practitioners of Ayurveda and Homeopathy to prescribe mainstream medicines like an MBBS graduate can. The NMC bill proposes to abolish Section 15 of the Indian Medical Council Act, which states that the basic qualification to practise modern medicine is MBBS, thus throwing open the doors for all types of alternative medicine practitioners to ply their trade in the mainstream and prescribe modern drugs without any fear of punishment.

In a report by Reuters in 2015 a worrying set of statistics indicated the quality of existing medical professionals and the sorry state of healthcare in India. The report highlighted, "About 45 percent of the people in India, who practise medicine, have no formal training, according to the Indian Medical Association. These 700,000 unqualified doctors have been found practising at some of India's biggest hospitals, giving diagnoses, prescribing medicines and even conducting surgery," it says. In other words, there seemed to be a total lack of any effective regulatory processes; either by the medical fraternity or the medical policing authorities of the national or state governments.

In a joint initiative of the Ministries of HRD, External Affairs, Home Affairs and Commerce and Industry, the government of India recently commissioned a 'Study in India'. The programme was mainly aimed at boosting the number of international students coming to India that was steadily declining with more students going to Singapore and Australia. It has made the visa process easier for foreign students and has included fee-waiver schemes.

This year, 15,000 seats have been offered by 160 institutions. The critics welcome the move for its potential to boost the economy and achieve better global rankings but also ask, "Will it benefit domestic students?" It is no secret that there are Indian students who have not been able to get admission into Indian institutions despite a good score, simply due to lack of availability of seats.

Health Care is often left in dire neglect on many levels mainly due to lack of strategic planning, effective structures for implementing monitoring and almost non-existence of clinical governance or care standards. Health Care has remained a low priority in the debate of political agenda, except sporadic bursts full of emotional anger when a fatality or irreversible harms are exposed now and then by the community and media alike. Where there is evidence of 'sanitation' and better services, the cost of high-quality clinical diagnosis and treatment as well as aftercare remains outside the range of affordability of the largest population of the country; mainly the poor and middle-classes. In the real India, the grass-roots reality is filled with exposed 'exploitation' of patients at almost every stage of their experience with the clinicians, where the system is purely driven by making monetary benefits; the culture of care is pushed to a lower level of priority, to put it mildly.

The Challenge:

Thus, it is a real challenge to address the debate on 'private sector vs public sector' and the relationship under the concept of public and private sector (PPP) arrangement that can sustain the core principles upon which the NHS was built.

The new cohesive strategic policy would need to be compatible with resource matching commitments against the interest of the thriving private sector. It needs more robust and unpopular implementation of monitoring and governance programmes which are at the core of the NHS policy powerhouses.

The government would also be subject to 'hands off' demands by the professional's community in medical- clinical and nursing, in order to protect their 'independence' and right to regulate the health care sector.

Engaging with all the stake holders on a common theme would be the real test of the government, particularly when the interests of many international educational and service providing agencies have found access through FDI's door.

The other option, to find ways of ensuring the development and growth of the private sector, is also workable but there would need to be mandatory access to their services by the poorest and those teetering around poverty, so that they can experience the benefits.

It is feared that 'insurance schemes' could easily be milked by the medical service providers by undertaking unnecessary examinations and retests, leaving the beneficiaries with the 'fait accompli', forced to seek further funds to meet the cost of their unfinished treatment.

Recommendations:

I would recommend that in the absence of any credible 'Planning Commission' that could provide a coherent and effective five-year strategic direction and delivery plan, the incoming government would need to consider establishing an independent judiciary commission in order to consult widely on the state of the health care of the nation to assist in providing a debate on the future of provisions.

This commission should preferably be led by medico-legal experts under Supreme Court guidance (equivalent to a Royal Commission). In addition, there should be a national Independent Health Observatory at state level to provide much needed insight into the performances that meet the needs of the country in the meantime. The government would need to develop much more healthy and effective debate with the training and licensing establishments in order to improve the 'core culture' that needs a shift in developing leadership in clinical governance as well as managing ethics where the environment for 'patient safety' takes priority.

Finally, any attempt to shift focus from 'customer based' (the gravy train) services to make profit,to the 'patient-centric' services that are based on the ethics of promoting services which are accessible to all at the point of need, regardless of the ability to pay, would be a 'poisoned political chalice' for any government in India! ❑

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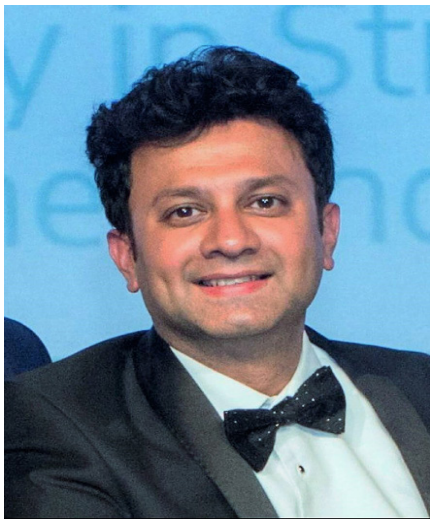
Prof JS Bamrah receives a CBE for services to Mental Health in the Honours List

Professor Jaswinder Singh BAMRAH received CBE for services to Mental Health, Diversity and the NHS in the Queen's Birthday Honours list.

Prof Bamrah, Consultant Psychiatrist at Manchester Mental Health NHS Trust and Honorary Reader, University of Manchester said, "I'm delighted and privileged to have been given such an honour by Her Majesty the Queen, especially as it comes on the 70th anniversary of the NHS.

Prof Bamrah is Chairman of BAPIO and Chairs its North Division. He also holds many other commendations, including the HSJ award for being one of 100 BME pioneer health leaders in the UK, an Association Medal from the BMA and acknowledged by 10 Downing Street as one of 100 doctors for providing a 'Distinguished service to the NHS'.

Dr Sanjeev Nayak won the prestigious award at Windrush cerebration.



Dr Sanjeev Nayak won the prestigious award during the celebrations of Windrush and 70 Years of NHS dinner at Manchester on 12th June 18.

Dr. Nayak is a Consultant Interventional Neuroradiologist at University Hospitals of North Midlands, introduced and pioneered Mechanical Thrombectomy for stroke patients in the UK. Dr Nayak was also voted at number 2 as one of the NHS top 10 stars at the Health and Care's Top 70 Stars award at the NHS Confederation conference. He did his undergraduate medical training from Kasturba Medical College, Mangalore, India. He has won several other awards for his pioneering non-invasive technique to help stroke patients.

Professor Iqbal Singh Appointed to Health Honours Committee

Professor Singh has recently been appointed to the Health Honours Committee, in the New Year Honours lists, for a period of three years in the first instance.

He is a member of platinum awards. He is chair of the global Centre of Excellence in Safety for Older People (CESOP) and has been a leading contributor to healthcare and medical regulation, as founder commissioner HealthCare Commission and was council member of the GMC.

He is member National Platinum Awards Committee and medical vice chair of Advisory Committee for Clinical Excellence Awards (ACCEA) North West and led the way for stakeholder engagement.

He is also chair of the GMC BME Doctors' Forum and a member of the Clare Marx Review Working Group.

Dr Hasmukh Shah honoured in the Queen's Birthday Honours list with BEM

Dr Shah, a GP in Wales for over 43 years received BEM in Queen's Birthday Honours List.

He is the honorary secretary of the Welsh Division of British Association of Physicians of Indian origin. Dr Shah is trustee of Sanatan Dharma Mandal &Hindu Community Centre Cardiff, Welsh Hearts, Race Council Cymru and The Mentor Ring, as well as being the chair for the Minor Ethnic Association for Ophthalmic Care (MEGAFOCUS) group.

His charity work included raising funds or school projects in India and orphan project in Africa.

Dr Shah was awarded visiting Fellowship by the University of South Wales in April, 2017 for his long standing medical professional work, education and charitable work to people of Wales.

KERALA FLOOD DISASTER BAPIO FUND RAISING APPEAL

Kerala has witnessed its worst floods in over a century. Twelve out of 14 districts have suffered severe damage to houses, roads and agricultural lands. Overflowing rivers and water released from dams resulted in the loss of over 400 lives and, according to one estimate, losses of almost Rs 35,000 crore. More than one million people have been displaced, many of them taking shelter in thousands of relief camps across the state. There is a fear of epidemic as the floodwaters recede. After completion of relief work, there is a daunting task of rebuilding damaged houses, social infrastructures and livelihood. BAPIO Charity would like to contribute to the massive rehabilitation efforts being undertaken. To supervise the fund collection BAPIO Charity has a formed a committee.

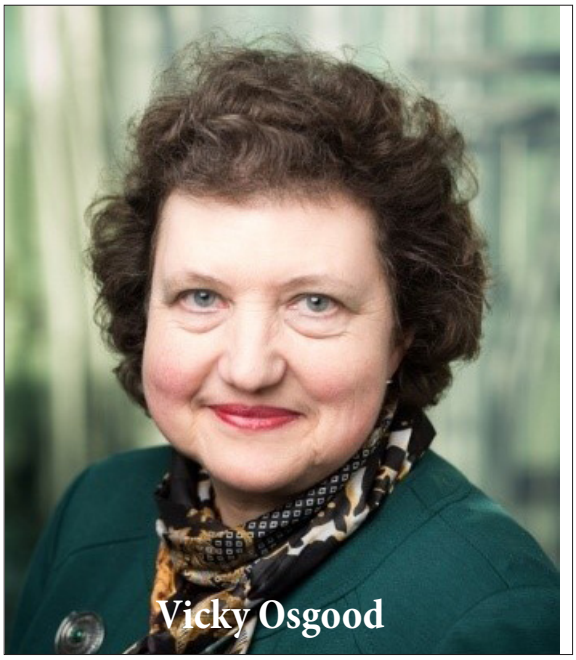
Please donate generously

Bank details for online transfer:

BAPIO Charity Account no: 00067914 Sort code: 30-90-66

BAPIO launched its India-UK Healthcare Policy Forum at the Indian High Commission in London on 8th August 2018. It aims to harness the contribution made by an estimated 60,000 Indian-origin doctors to the NHS and influence healthcare initiatives in both countries. The forum will be developing a network of experienced clinicians, policy-makers and entrepreneurs to provide advice and practical support to the health services in the two countries.

Remembrance



Vicky Osgood was the first female obstetrician in Portsmouth. Her life experience enabled her to approach the practice of obstetrics where she made the midwife an integral part of the care for all women. This led to her advocacy of multidisciplinary education in her later role as an educator. She became the Director of Medical Education in the Portsmouth hospitals and not long after that became Dean of Wessex and later Assistant Director for Postgraduate Education at the GMC. Whilst in this post Vicky became a Fellow of The Royal College of Physicians of Edinburgh. A part of her citation read, "Dr Osgood was an outstanding figure in medical education and training in the UK.

She was a good friend of BAPIO. She worked with the BAPIO and supported it in many endeavours.

Vicky leaves her husband of 40 years and 3 grown sons who will miss her sorely. She contributed so much to Postgraduate Education and there was so much more that she could and would have given. Her legacy will live on, not shouted from the treetops but whispered by all those who she has touched both knowingly and unknowingly. ❑

BAPIO AWARDS 2018

Professional Excellence and Leadership

Outstanding Contribution to BAPIO

Ms. Karon Monaghan QC

Karon has probably the most comprehensive discrimination expertise across the Bar. She practises principally in the field of equality and discrimination law, human rights and EU law. Her contribution to BAPIO in the historical judicial challenge has been unparalleled.

Women's Role Model

Prof. Bhupinder Sandhu OBE

Prof. Sandhu is a paediatric gastroenterologist at Bristol Royal Hospital for Children. She has been responsible for establishing and developing the paediatric gastroenterology and nutrition unit. The University of the West of England awarded her the Honorary Degree of Doctor of Science in recognition of her outstanding contribution to public services and charities. She is a role model for women in science and medicine.

Contribution to Equality and Diversity

Prof. Mala Rao OBE

Prof. Rao is a senior Clinical Fellow at the Department of Primary Care and Public Health, Imperial College London & Honorary Consultant at Public Health England. She is Vice Chair of NHS Workforce Race Equality Standards Advisory Group. She has been actively involved in promoting awareness of inequalities in accessing hospital care in Andhra Pradesh and Maharashtra states of India. She has helped developing the Rajiv Aarogyasri community health insurance scheme of Andhra Pradesh.

Imran Yousaf Memorial Award

Dr. David Sellu

Dr Sellu, a colorectal surgeon, was convicted of gross negligence manslaughter in 2013 and sentenced to imprisonment. His appeal against the conviction was upheld by the Court of Appeal in 2016. Imran Yousaf memorial award is awarded in recognition of his great courage in sustaining his dignity despite such an unfair treatment.

Young doctors Award:

Dr. Pooja Arora

Dr Arora, a young bright GP in Birmingham is determined to make a positive change for her peers. Her keen interest is in promoting young GPs and GP trainees' roles in the future of General Practice. She has been voted as a rising star in "Pulse Power 50" in 2015.

Young doctors Award:

Dr Sapna Shah

Sapna Shah qualified with first class honours in Medicine and Biochemistry from University of Bristol. She was appointed as a consultant at King's College Hospital in 2009 and an honorary senior lecturer in 2017 at King's College London. She was awarded PhD from Queen Mary University of London. She is an educational and clinical supervisor for renal CMTs and SpRs. Sapna is a Principal investigator for several the NIHR studies in the field of Kidney transplantation

Professional Excellence

Mr Babulal Sethia

Mr Sethia, a Consultant Cardiac surgeon at the Royal Brompton hospital is known for his philanthropic/charitable work. He was appointed by Her Majesty as the Deputy Lieutenant of London which is one most prestigious social honour that very few of us can aspire and achieve. The former President of Royal Society of Medicine has a vast clinical and managerial career behind him.

Excellence in Leadership:

Mr Nigel Acheson

Mr Acheson is a CQC Deputy Chief Inspector of hospitals and a consultant gynaecological oncologist. Nigel actively promotes quality improvement and the involvement of patients as partners in their care. He co-chaired the regional NHS England/Public Health England sustainability programme. As a Regional Medical Director he held many higher-level responsibilities for the South Region of NHS England where he served on the national groups for diabetes, cancer, maternity and 7day-services. He was awarded Founding Senior Fellowship of the Faculty of Medical Leadership and Management.

Excellence in Research & Innovation

Dr Sunil Daga

Dr Daga Consultant Nephrologist and Transplant Physician at St. James's University Hospital, Leeds Teaching Hospitals NHS Trust. He has made invaluable contribution to the BAPIO innovation and training initiatives, including encouraging abstracts submissions and posters presentations. His special interests are the Renal transplantation, Antibody incompatible transplantation and Organ donation.

BAPIO Doctor of the Year award

Dr Jonathan Cusack

Dr Cusack, a Consultant Neonatologist and a lead for Neonatal Education at the University Hospitals of Leicester has made extensive contribution in research with a number of publications to his name. He has played an active role in clinical governance at all levels for reducing clinical risks. Above all, he has been the champion who supported Dr Hadiza Bawa-Garba as her educational supervisor. He worked extensively to support her through a very public case of Gross Negligence Manslaughter, involving complex legal challenge. His conduct in supporting a junior is an example for all professional.

NHS70 Awards

To mark the celebrations of the 70 years of NHS, BAPIO salutes some of the great contributors of Indian Origin to this national Institution.

We congratulate the following doctors and celebrate what they represent as Consultants, General Practitioners and SAS doctors – the backbone of the NHS.

So we pay tribute to **Dr Mohini Achar,** SAS doctor; **Dr Ripudaman Singh Deo,** Consultant Psychiatrist; **Dr Rajesh Kumar**, Associate Specialist in Anaesthesia; ***Dr Y.K. Gupta***, General Practitioner; ***Dr Mahavir Varshney,*** General Practitioner; and **Dr Bapuji Rao Velagapudi,** Consultant Psychiatrist.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