Special Issue November 2017 I Volume 1 Issue 9

SUSHRUTA

JOURNAL FOR DOCTORS AND DENTISTS

Integrating Healthcare:
- a new challenge for NHS!

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- Should cannabis be legalised in UK?

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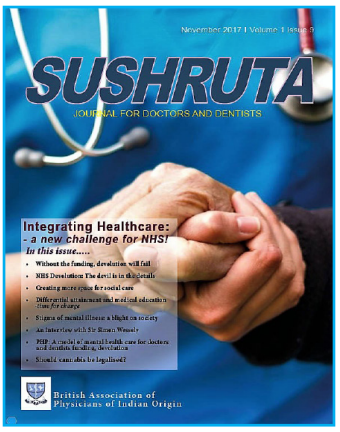

SUSHRUTA

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British Association of Physicians of Indian Origin is a national voluntary organisation established in 1996 to support the doctors originating from the Indian sub-continent. *Sushruta* is named after one of the earliest surgeons in India(600 B.C.), known as 'the father of 'plastic surgery'.

Disclaimer: The opinions and views expressed in this publication are not necessarily those of the editorial team or the publishers. Although care is taken in preparing of this publication, the editors and the publishers are not responsible for any inaccuracies in the articles and quality of the artwork provided by the contributors.

Foreword from the Editor

Dr Parveen Sharma
Consultant Psychiatrist
Member of ACOMHs advisory Group RCPsych.
Organising secretary BAPIO AC 17

I extend a warm welcome to delegates at our annual BAPIO conference for 2017 in the historic city of Manchester. This is a special year in the history of our organisation; our dear President, Ramesh Mehta, was recognised in the Queen's Birthday Honours List with an OBE for services to the NHS. I am sure you will agree that this is a well-deserved accolade for Ramesh, who has always led from the front and we at BAPIO are very proud of him.

The theme of the conference 'Devolved Health Care: Integration or Fragmentation' is an apt one as Manchester is leading the country in implementing the devolution of health care. Kailash Chand offers cautious optimism for the Manchester project, highlighting that it has strong leadership under the new Mayor Andy Burnham. The challenges faced by social care in these times of austerity present a threat to the proposed integration of health and social care and Parag Singhal and Dr Arun Baksi offer a way out with innovative solutions. Buddhdev Pandya argues that it is of paramount importance that devolution has strong clinical leadership at its helm, setting out a detailed analysis of how it can impact on the outcome of the process. CR Selvasekar, surgeon par excellence reflects on the delivery of specialist services in Manchester.

One fascinating piece is our trainee rep Devena Sharma's exclusive interview with Professor Sir Simon Wessely who muses over his new role as Regius Professor and gives us personal insight into what makes his marriage tick. His praise for BAPIO has not gone unnoticed, and I can confirm that no brown envelopes changed hands! Equally fascinating is a helpful insight by Professor Dame Parveen Kumar on the leadership role of women in an interview with one of our rising stars, Pooja Arora.

The issue of stigma continues to haunt patients with mental health problems across the globe. JS Bamrah, our Chairman and leading psychiatrist, looks at the topic in detail and offers helpful suggestions to tackle it. Seamlessly then, Clare Gerada notes that the taboo of mental illness does not spare even medical and dental health professionals. She summarises the impact of NHS Practitioner Health Programme as it enters into its second decade.

Further along, Anthea Mowat gives a BMA perspective on tackling differential attainment in medical training, which she succinctly points out, requires joint working across all organisations responsible for and supporting junior doctors. Another facet of discrimination faced by BME staff is that of ethnic minorities representation, or lack of it, across public health sector leadership roles. Neeraj Bhala critically evaluates the role of available data in informing the issue.

Healthy population is the best antidote to NHS Crisis, 'The Pioppi diet' outlined by Aseem Malhotra is the best recipe in health. JS has helpfully reviewed it.

Indo-UK collaboration has been a major BAPIO initiative. Prof. Raj Murali informs of Edge Hill University PG Programme which offers opportunity to overseas trainees to work fulltime in NHS.

Finally, I felt a bit of controversy would help with the mass circulation of this edition of Sushruta which I have had the pleasure to edit. So I expect you will be suitably entertained by the reflections of JS Bamrah and Kailash Chand on the legalisation of cannabis debate which was recently a feature of the BAPIO NW CPD meeting.

I hope you find this issue with its rich flavour of contributions on devolution in healthcare and other important issues across the NHS an interesting and useful one. My grateful thanks to the editorial team and all the contributors. Do contact me or anyone in my editorial team if you wish to make contributions for forthcoming issues. ❑

Message from Jon Rouse

Jon is Chief Officer for Greater Manchester Health and Social Care Partnership to coordinate the delivery of Greater Manchester's strategy for the transformation of health and care services.

"I am delighted to extend my support to BAPIO, which champions the work of doctors, dentists and medical students of Indian heritage. Your work in developing excellence in patient care, growing the next generation of future leaders and your commitment to equality should be held up by others as a shining beacon.

Overseas doctors make a valuable contribution to the NHS here in Greater Manchester. Our city-region has always been a place which welcomes people from all over the world and we are pleased to support the training and development of Indian doctors and dentists in our surgeries and hospitals. This relationship is beneficial to all, helping to fill an immediate recruitment need, as well as offering high quality training.

There is still a lot of work to be done to accelerate the pace of change around inclusion. I am a passionate advocate for a diverse NHS and BAPIO forms the fabric that mirrors our values and commitments for a global and welcoming NHS. Your desire to improve global health inequalities is to be applauded."

Message from the President of BAPIO

"Collaboration gives the freedom to come out form the narrow scopes of life to the field of endless possibilities." Amit Ray

I am delighted to welcome delegates to the BAPIO Annual Conference 2017 to the inspiring and beautiful settings of Lancashire Cricket Club. With our love for cricket, this is indeed a great venue for a BAPIO Conference.

The theme of the conference on devolution is most appropriate for a meeting in Manchester and Devo Manc is likely to be trend setter for the future of National Health Service. We have a very impressive line-up of speakers and I am particularly pleased to welcome Andy Burnham, the first Mayor of Greater Manchester, who will be playing a major role in the success of devolved healthcare.

The workshop on Indo-British collaboration carries huge significance in the context of the current crisis in health care in the UK and challenges in health care provision faced by India. I am delighted that we have many influential leaders in healthcare from both the countries joining in the discussions. I am thankful to Ged Byrne and Health Education England for being partner in organising this workshop.

BAPIO believes in collaborative approach in improving quality of patient care as well as to promote equality and I am very pleased that we have excellent relations with GMC, Royal Colleges, HEE, DH, BMA and other healthcare bodies in UK and in India. Differential attainment continues to be a major concern and we have ongoing engagement with the establishment.

BAPIO women's forum has been proactive and recently organised an excellent conference at Bristol. BAPIO patient safety forum organised a very successful national conference at Birmingham. BAPIO Paediatric forum has developed close links with RCPCH and plays important role at its annual conference. I am pleased to report that BAPIO Political Forum will be launched during the conference to promote our policy objectives of inclusion and equality. Amongst our various divisions, the Welsh, South West and North West have been particularly proactive and deserve kudos.

Medical Defence Shield (MDS), an independent BAPIO subsidiary now in its eighth year, continues to grow and is successfully assisting hundreds of doctors in difficulty. BAPIO Training Academy (BTA) in collaboration with HEE is on the verge of launching a major International fellowship programme to assist Indian doctors to train (& return) and NHS to get staff at crisis time.

Finally, thanks to the organising committee of the conference, very ably led by Drs J S Bamrah, Kailesh Chand, Chelliah R Selvasekar, Parveen Sharma and Jaspal Dua and others, for their hard work to ensure another very successful BAPIO Annual Conference.

I wish a most educational and enjoyable time for all delegates.

Ramesh Mehta OBE
President - BAPIO

Message from H M The Queen

BUCKINGHAM PALACE

3rd November, 2017.

Dear Dr. Sharma,

The Queen has asked me to thank you and the Members of the British Association of Physicians of Indian Origin for your letter sent on the occasion of your Annual Conference which is being held from 24th to 26th November.

Her Majesty appreciated your thoughtfulness in writing as you did and, in return, has asked me to send her warm good wishes to all those who will be gathered at Old Trafford Cricket Club in Manchester for a most successful and enjoyable programme.

Yours sincerely,

David Ryan

David Ryan
Director, Private Secretary's Office

Message from
First Secretary of State and Minister for the Cabinet Office

"The NHS is one of the UK's best loved institutions, and overseas workers play a crucial role in delivering services to UK citizens." The Rt Hon Damian Green MP

Damian Green is a Conservative MP for Ashford since 1997. He is an experienced producer and presenter specialising in business programmes. He joined John Major's policy unit and worked for 2 years. He held a number of positions in the Shadow Cabinet, including Shadow Secretary of State for Education and Skills, Shadow Secretary of State for Transport and Shadow Minister for Immigration. He served as Minister for Policing, Criminal Justice and Victims and later became Minister of State for Immigration. From July 2016 to June 2017, he was appointed as Secretary of State for Work and Pensions.

Cabinet Office

The NHS is one of the UK's best loved institutions, and overseas workers play a crucial role in delivering services to UK citizens.

It is fantastic to see groups such as the British Association of Physicians of Indian Origin (BAPIO) demonstrating a commitment to delivering high quality patient care, and reflecting the government's ambition of delivering world-class public services. BAPIO's drive to empower its members to be "beacons of leadership and professional excellence" is something that I applaud, and something that all sectors should strive to emulate.

Diversity in the public sector is something that the government takes seriously in order to deliver the best-quality services to the public, and it is great to see groups such as BAPIO working to deliver this.

I would like to thank you all for your contribution to our health service, and wish you all the best for the conference.

Damian Green MP
First Secretary of State and Minister for the Cabinet Office

Welcome to the BAPIO Annual Conference

Message from Mr Andy Burnham

Andy Burnham is the Mayor of Greater Manchester.

"Indian doctors have for many years made a valuable and important contribution to the NHS, especially in key services where there has been a historic shortage of UK-trained doctors.

The British Association of Physicians of Indian Origin (BAPIO) is a powerful voice for international Doctors in the UK. The BAPIO conference in Manchester is an opportunity to recognise the tremendous amount of work these doctors are continuing to do.

I'm delighted to be part of this conference with such eminent speakers and I am sure it will be a success.

The profession and the NHS have benefited from the contribution of Indian doctors and I truly thank them for all they have done and all that they continue to do for patient care in the NHS."

"I want to build here the country's first National Health and Care Service by bringing social care out of the private sector and into the NHS."

Andy Burnham is the Mayor of Greater Manchester. in office since May 2017. Burnham was previously the Member of Parliament for Leigh from 2001 to 2017. He is a member of the Labour Party. Prior to this, he was MP for Leigh from 2001. In government, he has held Ministerial positions at the Home Office, Department of Health and the Treasury. In 2008 he became Secretary of State for Culture, Media and Sport, before returning to Health as Secretary of State in 2009. In opposition, Andy has served as Shadow Education Secretary, Shadow Health Secretary and Shadow Home Secretary. In his role as a the Mayor of Greater Manchester is involved in oversees the £6billion devolved health and social care budget via Greater Manchester's Health and Social Care Partnership.

Welcome to the BAPIO Annual Conference

Message from Simon Stevens

Chief Executive, NHS England

Throughout its history, the National Health Service has relied on the outstanding commitment and expertise of many thousands of physicians of Indian and South Asian origin.

As the NHS approaches its 70th birthday, it is a good moment to reflect on the staff who have worked tirelessly to meet the needs of our patients over the last seven decades.

Quite simply, the NHS would not be all that it is today without you.

So congratulations to BAPIO for its outstanding work in representing, supporting and developing doctors working across the NHS.

" The accountable care systems are the biggest national move to integrating care of any major western country".

Simon Stevens is CEO of NHS England, which leads the NHS's work nationally to improve health and ensure high quality care for all. He joined the NHS in 1988 under the Graduate Training Scheme. Subsequently led acute hospitals, mental health and community services, primary care and health commissioning in the North East of England, London and the South Coast. He also served seven years as the Prime Minister's Health Adviser at 10 Downing Street, and as policy adviser to successive Health Secretaries at the Department of Health. Simon has spent a decade working internationally, leading health services in the United States, Europe, Brazil, India, China, Africa, and the Middle East. Simon was educated at Oxford University; Strathclyde University, Glasgow; and Columbia University, New York where he was Harkness Fellow at the New York City Health Department. He has also been a trustee of the Kings Fund and the Nuffield Trust, visiting professor at the London School of Economics, and an elected local councillor for Brixton in South London.

Without the funding, devolution will fail

"We are in uncertain times for the future of our NHS."

Dr Kailash Chand

Kailash Chand is honorary vice president of the British Medical Association (BMA) and has worked as a GP since 1983. He is ex-chair of Tameside and Glossop NHS

In a surprise deal on 2nd November 2014, George Osborne, a Conservative Secretary of State for Finance, and Sir Howard Bernstein, the then CEO of Labour controlled City of Manchester, signed an unprecedented derogation of power from Whitehall to Greater Manchester. Thus, Greater Manchester became the first English region to be handed full control of its £6bn health budget. Devolution Greater Manchester, or DevoManc as it is commonly dubbed, holds out the promise of meaningful and deep integration within the health service, and between health and social care.

This integration has great potential to offer real benefits to patients. In particular, it could help to deliver genuinely patient-centred and coordinated care on a locality basis. The existing barriers created since the origins of the NHS in 1947 between primary care, hospitals and social care are being redefined so that care can be seamless and less fragmented. The economic disparity between London and Manchester had created a health gap that could only be redressed by bringing the NHS under local control.

Of course the devolution of powers to Greater Manchester is not without risks. Aside from the reputational risk, the first requirement is to ensure that the public in general is on board and actually understand the scope and limitations of DevoManc, and then there is the more serious challenge of meaningful engagement to deliver its strategy and aspirations. Much of this was set up in the MOU that was signed in April 2015 with the aim that 'All decisions about Greater Manchester will be taken with Greater Manchester'. This is an experiment that we can't afford to botch-up otherwise it will emit toxic fumes for a long time to come.

While people want to have their voices heard, I am concerned that up until now our public, the voluntary sector and professionals have not been offered sufficient involvement in the devolution process. Some don't know what it is, whilst others see it as just another layer of bureaucracy – another political gimmick and less power for the people. These new deals have been done with no public awareness, no public consultation, no democratic engagement, no scrutiny and no impact assessment.

The NHS in Greater Manchester is under intense pressure with more than 200,000 patients on the waiting list and hospital deficits hitting record highs. As hospital figures reveal, more than half of NHS Trusts are unable to balance their books and nearly three-quarters of NHS trusts have seen patients waiting more than 100 days for discharge in the past three years.. If there was ever any doubt of the evidence, it has lately become patently obvious that austerity has had an adverse impact on key aspects of patient care such as operations, cancellations of clinics, delayed discharges, etc. It is clear now, more than ever, that chronic underfunding is preventing NHS staff from providing patients with the level of care they deserve.

Devolution presents a real opportunity for Greater Manchester to deal with some of the problems facing the NHS, and also some of the more longer-term public health challenges, especially around health inequalities in a diverse population where health outcomes are significantly worse than the rest of the country in many areas such as respiratory disease, stroke-related illness, cancer, psychiatric disorders, etc. But without the right financial support, it is going to be an uphill task running our clinical services, let alone meeting with the health and social challenges.

Social care in particular is in an abyss – in Greater Manchester for 2016/17, we are facing an £81m black hole in social care funding, rising to almost a quarter of a billion pounds by 2020 – yet this Government feels grammar schools are a greater funding priority than care for older people.

One of the real issues for this devolution is to ensure that all services remain stable and are invested in and that we don't have a situation of robbing Peter to pay Paul.

The threats and the opportunities are significant. If the DevoManc team do not use the £6bn devolved budget in a radically different way around our health and social care system, it will face a major deficit of £2bn by 2021 – a recipe for another NHS reorganisation failure.

The NHS has already been seriously damaged by the policies of all three major political parties in the last decade. If this continues, England will have a completely different healthcare system in five years' time – 'NHS' in name alone. Things will be much worse in terms of access, equity, health outcomes and cost.

However, Manchester devolution can be an inspiration for the rest of the country when it comes to creating the NHS of the future

Conclusion

I feel passionately that with Andy Burnham, the new mayor of Greater Manchester, and Jon Rouse, chief officer of health and social care partnership, fighting our corner, championing Greater Manchester nationally and internationally our prospects are much brighter than if it were to be left to Theresa May in Westminster. Manchester as Andy says, is the home of radical forward thinking and we have a real job of work to do to change a 20th Century treatment service into a 21st Century health promotion service. We have the ability to be the pioneers of that paradigm shift."

With a Mayor with real power, real clout and real influence, we are in a stronger position to ensure that the interests of our great region of Greater Manchester are not just protected as we leave the EU, but that we flourish, thrive and achieve our amazing potential. Make the NHS and social care, safe and best. ❑

Surgical services in Devolved Manchester

"There is a culture change required at the grass root level for this project to succeed and clinical engagement is paramount."

Mr CR Selvasekar
MD, FRCSEd (Gen), MFSTEd, Pg Cert (Med Ed), MBA
Consultant General, Colorectal, Laparoscopic & Robotic Surgeon.
The Christie NHS Foundation Trust, Manchester. M20 4BX.
MCh Pathway lead for Surgical specialities,
Hon Sr. Lecturer, Edge Hill University.

Devolution Manchester is a pilot project to provide devolved health and social care to the population of Greater Manchester under the leadership of the Mayor. Department of Health has provided £ 6 billion towards this project to provide health and social care for a population of 2.8 million.

This project aims at integrating health and social care. Currently there is fragmentation and the ultimate aim of this project is to bring a system wide change and to have health and social care under one roof. It also aims at decentralization of health care where decisions are made locally without interference from the central government. This ultimately is aimed at providing safe and high quality care, if implemented well.

Surgical Services: At present specialist general surgical management is provided in most of the hospitals in Greater Manchester. With the unified approach, acute abdominal surgery is planned to be offered at high quality in four major sites. These four primary sites include The Royal Oldham Hospital, The Salford Royal NHS Foundation Trust, Manchester University NHS Foundation Trust and Stepping hill Hospital. These four sites are also the sites where major emergency surgery will be offered under the healthier together initiative. The other sites currently offering surgery will be downgraded to provide basic elective care with support from these four major sites. To be successful this programme needs investment, patient focused standardized pathways and a major culture change among the clinicians to work at multiple sites with flexible job plans.

Specialist surgical services: Devolution Manchester project allows for centralization or regionalization of specialized services. There is high quality evidence in complex gastrointestinal surgery such as oesophagogastric surgery, pancreatic and advanced pelvic surgery where high volume and improved outcome relationship has been demonstrated. Devolution Manchester with its unified approach allows better infrastructure to be placed in a centralized unit with clinicians dealing with complex issues on a regular basis to provide improved outcomes for the local population.

Research: This unified project allows recruitment of patients for clinical research easier with various organizations collaborating such as the Manchester academic health science centre (MAHSC) which includes partnerships with Manchester cancer research centre (MCRC), major provider trusts and commissioning groups in Manchester. This provides an opportunity to translate newer cutting edge treatments to be brought to forefront clinical use sooner than what is currently possible and hopefully eliminate the various bureaucratic processes.

Education and Training: There needs to be a radical review of the current models of surgical training whereby the trainees are attached to one hospital and have varying levels of service and educational commitments. To train surgeons for the future, we need to allow trainees to have flexible contracts with hospitals in the Greater Manchester and training based on the trainee needs on a competitive basis. We also need to develop a robust mentoring and support programme to provide optimal guidance based on the educational needs which can be addressed in a structured and systematic process based on the performance.

Challenges: NHS has gone through various reorganizations and this project signals reorganization without properly evaluating the effects of the previous restructuring. Unfortunately this seems to be recurring theme of the modern NHS! Various well thought initiatives are discussed but not implemented and there is virtually no learning from the failures. There is a culture change required at the grass root level for this project to succeed and clinical engagement is paramount. Unfortunately there has not been public consultation nor has there been effective communications of the various actions taken so far. Finally for this system wide change to be successfully implemented £6 billion is not enough!

Conclusion: Devolution Manchester is a radical system wide change in providing integrated care allowing improved access for patients. It aims to eliminate variation, facilitate standardization and equitable care. It is possible for patients to have care closer to home for common conditions and to have specialized care centrally at high volume well resourced centers. This project allows for the use of modern information technology and by working together various organizations can engage in developing patient specific pathways to provide high quality equitable care for the local population based on the local needs. This project has the potential to provide sustainable health and social care to Greater Manchester but needs a thoughtful implementation. ❑

NHS Devolution: *the devil is in the details!*

"While we welcome devolution, it is time to place the clinicians in the driving seat of planning services."

Buddhdev Pandya MBE
Managing Editor of Sushruta and 'The Physician'- medical journal. Former Director of Corporate Affairs and Policy of British Association of Physicians of Indian Origin. He has headed as director many Race Equality Councils. He is Publisher and designated Managing Editor of APEXInnovation360^0 - journal of healthcare science and technology.

In 2015, then the Chancellor George Osborne surprised Manchester with an announcement that £6 billion of health and care spending would be devolved to Greater Manchester.

The proposal was hailed as representing a big offer to the northern powerhouse. Mr Andy Burnham, in opposition at the time, reacted with criticism that if he were health secretary he "wouldn't be offering this deal".

In contrast, of the ten councils that signed this deal eight were Labour-controlled. Even Lord Peter Smith, Labour, who was chair of Greater Manchester Combined Authority had felt that the plans would mean services could be tailored around the needs of people living in Greater Manchester.

Earlier, Ed Miliband, the Labour Leaders was advocating for a new culture of public services where power wasn't simply devolved to people but to councils.

In 2012 Burnham, spoke at the King's Fund where he argued for fully integrating health, mental health and social care into a system of whole person care. He envisaged the role for the NHS limited to merely an 'advisory' status, giving more responsibility to the local government.

Mr Simon Stevens, the Chief Executive of NHS England said, 'As the NHS approaches its 70th birthday, we are now embarked on the biggest national move to integrating care of any major western country. He pledged to end the 'fractured' health and social care system, reducing an unnecessary journey from pillar to post for many patients.

Sir Bruce Keogh, NHS England medical director wants tear down those administrative, financial, philosophical and practical barriers to the kinds of services our patients want us to deliver.'

This year in June a second Greater Manchester-style devolution deal has been struck in Surrey Heartlands. The Health and social care devolution deal was agreed. The Conservative Government has made local devolution within the cities and regions of England one of its central policy reforms. Eight more accountable care systems (ACSs) are expected to bring together local NHS organisations, in partnership with social care services and the voluntary sector. Mr Stevens has described the accountable care systems as "the biggest national move to integrating care of any major western country".

This returns us to the political rhetoric of the need for more funds for the NHS. The total spending on health in England is predicted to rise to over £125 billion by 2020. The NHS is also being asked to find £22 billion in austerity savings by 2020, when it needs to keep up with rising demand.

The Government claims that it will be giving the NHS an extra £10 billion by 2020. As the war of words escalates, the leader of the Opposition feels that the NHS is in crisis and has accused the Prime Minister of being in denial.

The reality is that the modern NHS faces severe pressures, with most of the NHS trusts across the country spending more than the revenues they can bring in! However, one can barely remember a period when the NHS was without the cry for more resources!

There is a more sinister devil embodied in the NHS culture requiring greater strategic intervention. In February 2016, the Labour Peer, Lord Carter in his final report advised Health Secretary Jeremy Hunt that hospitals must standardise procedures, be more transparent and work more closely with neighbouring NHS trusts. His report identified many areas where 'prudent' management can help save funds and make the services more efficient. He said, "implementing the recommendations in his report will help end variations in quality of care and finances that cost the NHS billions".

There is a huge shortage of consultants and nurses, in addition to a decreasing number of GPs in the system. The trade unions are claiming that the chaos is due to the mismanagement of the workforce, while the Government maintains that there are more places to fill than the shortages! Meanwhile, trusts are heavily reliant on locum doctors and nurses, spending millions that benefit private sector agencies.

Speak to any NHS clinician or front-line worker, and most would be able to point out, both the mismanagement and waste of resources that otherwise could have helped improve services.

The reason they feel that way is borne from their experience in real time and impacts upon the careers of the carers, clinical personnel and others involved in front-line service provision.

More seriously, patient safety is severely compromised when the administration is muddled, and limited resources are poorly employed! There is an atmosphere of sheer frustration that the management – the NHS Trust Boards – are failing to listen or act upon their concerns

Over the years, many trusts seem to have found themselves riddled with complex disputes between the staff and their managers. The culture of fear, distrust and unfair treatment through grievance and disciplinary processes has become a common experience of most victims of the system. Often the 'club culture' pounces on the victims when it comes to claims of bullying, whistle-blowing or simply asking for rights to be respected.

The rapid turnover of managerial staff, jumping from one senior position to another, is also largely evident. Most clinicians would agree that those at the bottom of the 'food chain' remain no more than spectators, with little recognition offered.

These issues have led to the

Devolution: the devil is in the details! Continuation .....

wasting of time and resources in many ways. It has brought into question the issue of competence of the supervisors and managers in fulfilling their responsibilities more prudently.

Instead of clinicians with expertise leading the processes and being engaged in improving the outcomes, a plethora of bureaucrats virtually dominates the planning and mechanism of the services. Their rivalry can even lead to failure to resolve issues amicably or provide empowerment to the individuals in the workforce in order to contribute towards improvement. The consultation processes in most cases are merely an exercise in ticking boxes to endorse fancy tag-lines and slogans of various campaigns promoting exemplars of good service.

Considering primary care, including the GP services, referral processes, A&E and community care provisions, all are in a desperate situation.

The board of directors of the NHS trusts largely rely upon the expertise of their chief executives, human resource directors and medical directors to provide strategic policy guidance and a logistical roadmap to achieve the implementation of good governance. In all practical sense, these post-holders are the 'movers and shakers' with the boardroom. The key to the change is that those holding senior positions need to be in tune with their own workforce and managers.

Tackling troubled hotspots and influencing the dynamics of change is an uphill struggle, with the ultimate responsibility resting upon the board members, their potential, and the political will to hold these persons accountable.

Thus, the NHS trusts cannot escape their responsibilities in taking proactive steps to provide more conducive working conditions to improve efficiency. First, there must be recognition that there is huge waste through the mismanagement of human resources as well as processes, both requiring innovative lateral thinking.

If there is any notion of jugaad or innovative thinking, then the Government should begin reviewing the composition, the powers and the regional accountability processes of the NHS Trusts and the associated agencies under 'devolution of autonomy'.❑

Devolution of Healthcare: *Key observations*

Dr Parveen Sharma
Consultant Psychiatrist, Member of ACOMHs advisory Group RCPsych.
Organising secretary BAPIO AC 17

A 'new era for Greater Manchester' started on 1 April 2016, as the region became the first in the country to take control of its combined health and social care budgets – a sum of more than £6 billion. However, the notion of devolving health care was not core to the original devolution agenda, which focused on driving local economic growth. The inclusion of health and social care in the so-called 'Devo Manc' agreement announced in November last year therefore came as a surprise to many. What it meant is that public consultation has suffered as a consequence.

The NHS also has a long history of central control, as evident in Aneurin Bevan's famous dictum that 'when a bed-pan is dropped on a hospital floor, its noise should resound in the Palace of Westminster'. Aneurin Bevan's proposal were opposed by Labour politicians notably Herbert Morrison.

However, The NHS Act, which came into effect in 1948, saw the transfer of local authority- run hospitals to the new National Health Service. Responsibility of community health services and public health were also transferred to the NHS in 1974. This legislation, along with the National Assistance Act, which also took effect in 1948, gave rise to the separations between health and social care.

Devolution from national to local bodies is, of course, not new to the NHS. A succession of policy initiatives has sought to increase the level of local autonomy in health – for example, the introduction of foundation trusts and the establishment of clinical commissioning groups (CCGs). Despite these intentions, however, this promised autonomy has arguably not yet materialised; the centre still steps into operational matters.

Since 2010, however, there has been consensus across all the major political parties that power in England should be devolved away from the centre towards local communities on a much larger scale.

National Progress: Since the launch of Devo Manc, following regions have had formal agreement and made initial forays into devolving health and social care.

Cornwall, London, Liverpool and Northeast. Although there are similarities to Manchester Model there are significant differences too, what is evident is that the devolution is not going to be 'one size fits all' exercise.

BME organisations – Crucial to the success story-BAPIO leads In Greater Manchester

With different regional models being the most likely outcome, it is imperative for the BME organisations to have local representation in the devolution exercise so that the issues pertaining to BME doctors and population are duly recognised.

BAPIO has a strong and vibrant workforce in regional divisions, the members need to proactively engage with the local authority's key figures to ensure that the process does not disadvantage the BME population and doctors. The local division has had discussions with key layers and the conference is an important step in progressing the endeavour further. ❑

Devolution of powers and funds from central government to local government has emerged as one of this government's flagship policies.

- Devolution has two mutually reinforcing objectives – to drive local economic growth, and to maximise the contribution of and value derived from public services, including health and social care.
- The inclusion of health within devolution deals could be seen as an extension to the policy direction moving us towards more place-based commissioning and decision making.
- Recent reforms have meant that population-based budgets are now split between CCGs, NHS England and LAs – with most NHS, public health and social care commissioning already devolved to local organisations.
- There has been ongoing policy focus on trying to integrate commissioning and provision of health and care services through a variety of initiatives such as:
  - Better Care Fund (BCF)
  - Integration pioneers
  - Integrated Personalised Commissioning (IPC)
  - 5YFV New Models of Care / Vanguards
  - Co-commissioning of primary medical care
  - Collaborative commissioning of specialised services
- Overlaid and joined up with these initiatives, devolution provides further opportunity to deliver services and support joined-up around people's needs. Together, these initiatives form part of a strategy to support the development of place based commissioning and joined-up care pathways to improve the integration of care for people in England.

https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/devolution-publication.pdf

Creating more spaces for social care

Shortage of hospital beds has been a constant feature of the NHS for many years. Because of the growing number of the elderly this problem is destined to continue rather than diminish. It is therefore imperative that we find alternative solutions to provide care homes for the frail elderly as a matter of urgency.

Parag Singhal MD,MPhil,FACP,FRCP(London)
Consultant Endocrinologist, Hon National Secretary - BAPIO
Dr Arun Baksi
Consultant Emeritus Physician

Introduction

It is worth stating some startling facts published in a recent report from the Department of Health (HC 18. Session 2016-17 26th May 2016).

- 62% of hospital bed days occupied by patients aged 65 or over.
- 18% increase in emergency admission of older people
- £820m estimated to be the gross cost to the NHS of older patients in hospital beds who are no longer in need of acute treatment.

Shortage of hospital beds has been a constant feature of the NHS for many years. Because of the growing number of the elderly this problem is destined to continue rather than diminish. Despite the above, hospitals continue to reduce beds with the expectation that the elderly in need of social care will be looked after within the community. To establish adequate long-term community care will take time. It appears that the duty to find more community places for the care of the elderly is that of social care and the local councils. Local councils in turn are perpetually short of funds to carry out many other functions expected by the tax payer. It is therefore imperative that we find alternative solutions to provide care homes for the frail elderly as a matter of urgency. Failure to take such an action now will result in great hardship, increasing number of cancelled operations and failure of hospitals to provide appropriate care efficiently. In the meantime, there is a need to increase care beds as a half-way house while awaiting transfer to permanent community care.

How is this to be achieved?

1. Reopen closed hospital beds and closed community hospitals. This would be cost effective only if such wards were used as part of social care rather than a hospital ward, and ideally be considered as part of social care. These wards would be staffed by carer (not nurses) and managed by manager acceptable to social care.
   Discussions with those who have experience of running care home for the elderly with level 2 difficulties suggest that to break even in a home of 40 beds cost approximately £100 per day per bed. This is considerably less than the cost of a hospital bed. Furthermore, the lack of beds regularly leads to cancellation of operations resulting in increasing the waiting list, frustration of patients and staff in addition to the loss of income because of patients being referred to other hospitals for care.
   It is important to note that these beds will be for the duration of time it takes to find a suitable place within the community. Management of these beds by social service will facilitate the process of transferring patients from hospital to permanent suitable accommodation within the community. It will also be a good example of collaboration.
2. Consideration should be given to the use of redundant hotel and guest house rooms off season. It is recognised that to undertake the use of these sites will require careful and pragmatic collaboration with social services and CQC authorities. These discussions should commence as early as possible. **Discussion about these matters will succeed only if the people concerned are prepared to find a solution rather than raise objections. At the end of the day, local authorities make most of the rules.**
3. Create day care facilities for the less frail
   For many reasons adults find it difficult to look after their elderly parents and grandparents. Modern life styles force both parents to go to work which makes it impossible for them to care for anybody during working hours. Often, such people must move away to different parts of the country to find employment. The provision of day care facilities will enable such people to look after the elderly at home rather than in a care home.
4. Commence urgent discussions with social services, local council, hospital authority, CCG and public health.

   i. Agree on not just to maintain the half-way house as described above but also to find ways of increasing the number.

   iii. To ascertain the reasons that have led to the closure of many care homes, and to find appropriate solutions.

   iv. Establish concrete plans for the creation of more care homes within the community.

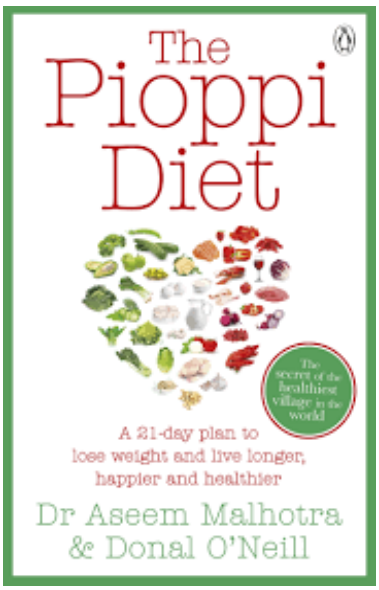
5. Carers have been treated with less respect than what they deserve. It is time society considered carers as undertaking a most valuable task. This should be reflected in their salaries and work conditions.

Benefits of the above changes –

- It will immediately enable ring fencing surgical beds thereby significantly reducing the number of cancelled operations.
- The change will improve patient experience and reduce their suffering.
- It will also lead to improving the sense of frustration of the surgical teams.
- The altered structure may well lead to the development of a meaningful joined up system involving all the sectors relevant to the provision of care.
- This change will enable doctors and nurses to move away from looking after medically stable patients and focus their attention to those patients who need medical and nursing attention thus addressing the shortage of medical and nursing staff in a significant way.

The Pioppi Diet:

A Potent Aide To Physical and Mental Health Well-being



by Dr JS Bamrah, FRCPsych.
Ex-Medical Director, Manchester Mental Health and Social Care Trust

A few weeks ago, the chair of the All-Party Parliamentary group on diabetes, the Rt Hon Keith Vaz MP in a parliamentary speech lauded a recently published book by internationally acclaimed cardiologist Dr Aseem Malhotra and his filmmaker co-author and former international athlete Donal O'Neill. Mr Vaz has even gone to the length of writing to 100 MPs with the highest prevalence of type 2 diabetes in their constituencies urging them to follow the Pioppi Diet - 21-day plan over summer recess and suggesting they ask their constituents to do the same.

Underpinned by robust science, and endorsed by many eminent doctors including researchers at the Cochrane Collaboration the book busts many myths that are prevalent in today's weight loss, exercise and medical industries; the misinformation of which the authors eloquently explain are root causes behind the twin epidemics of type 2 diabetes and obesity, the forme frust of morbidity and mortality in many seriously mentally ill patients, contributing to the burden on the NHS.

But the book also makes it very clear that improving population health and reversing obesity and type 2 diabetes will not happen without policy change that improves the food environment, by reducing the effective availability of junk food and sugary drinks in addition to making healthy food more affordable. It's easy to understand why Vaz who was the most vocal and perhaps influential MP behind the introduction of the sugary drinks levy to be introduced in the UK next year would give his full political backing behind the book which has also been described by the former secretary of health and now the Mayor of Greater Manchester, Andy Burnham as "having the power to make millions of people healthier and happier"

In fact reading through this highly informative and educational book it seems it was the message about the positive mental health impact of lifestyle choices contained in a number of areas resonated with me most. So far, many of the acclaims have been focused on physical wellbeing. I'd like to say that readers must also take home with them the many references the authors make to psychological wellbeing. It's often a circular argument whether being obese causes depression or whether being depressed leads to obesity. No one can deny however that there is a strong link between the two. Chocolate has long been associated with feelings of love and Sitophilia (sexual arousal through food), no Valentine's Day is complete without it. The neurobiology of this is interesting. Both chocolate and sex enhance serotonin and dopamine circulation, and it is no coincidence that depletion of these, particularly serotonin has been associated with depression while enhancing them has been known to improve mood. And the way the brain works is that it soon encourages repetitive eating behaviours that activate reward pathways, overruling the signals of satiety. And there are other foods too, such as refined carbohydrates that create a similar phenomenon. By focussing purely on calories and not where the calories come from we have become collectively addicted to consuming cheap sugar (added to over 70% of foods found in the supermarket) which being devoid of any nutrition keeps us constantly hungry. Breaking the sugar and refined carb cycle is crucial to helping control appetite that leads to over consumption. As Dr Aseem Malhotra himself told me, "you can tell people to eat less, but you can't tell them to stop feeling hungry."

One can perfectly understand why it's so hard for many to change their lifestyles when behaviour that is based on giving rewards with such foods reinforces the need for those rewards, regardless of whether or not it is a risk to health. Even the most ardent smoker knows that smoking is bad for health, and yet modifying behaviour in these individuals against the tide of the pangs of joy and satisfaction, however short-lived, are pretty hard to overcome. The Pioppi diet seeks to instil a discipline into one's dietary habits so that such reward systems do not take primacy. The authors emphasise how their twenty-one day health intervention will help you to 'tune into your body' and make those subtle changes we need, by the way we eat, sleep and what they promote as mindful movement rather than pure exercise. What really intrigued me about the book was the extent to which it dwells on not just the Pioppi diet but also some real gems in regards to improving our psychological health. The power of good quality sleep is mentioned - lack of sleep affects our cognitive functioning, and lowers our resistance to insulin. Repeated sleepless nights can thus result in significantly reducing our performance all around and has a major impact on us snacking or making poor choices in what we eat.

The authors also refer to social isolation as being a growing western phenomenon, one that can lead to depression, alcoholism and altered food hygiene. Over a million men and women over the age of 50 in the UK suffering from severe loneliness is a deeply disturbing statistic that can only be genuinely tackled by a holistic society wide approach and cultural shift to how we interact with each other. And the dye of our behaviour is cast during our formative childhood and teenage years so it was good common sense when Anne Longfield, the Children's Commissioner, remarked only last week that social media is the internet equivalent of junk food. Wouldn't it be terrific if during their formative years our younger generation modelled their living styles more broadly with better social interaction and natural ways of living? The Pioppi way is not to go for an hour on the treadmill or an exercise bike in the gym but rather to go out for a walk preferably in company.

An old fashioned way of staying physically fit perhaps, but almost certainly an 'organic' way to keep all our sensory systems (sight, smell, speech, etc.) alive and vibrant. A quote by Aristotle which I was not previously aware of, is especially germane to this issue: "Without friendship, no happiness is possible".

And finally, the authors describe how they encountered a real sense of serenity, tranquillity, togetherness and laughter in this remarkable community in Pioppi. I sensed then that the book is an excellent depiction of what it takes to secure the secrets of optimal health, happiness and longevity.

Live the Pioppi way, and make this book the first thing you pick up from the book store or from Amazon tomorrow!

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Differential attainment and medical education - *time for change*

Differential attainment in medical training has been recognised for decades as an issue which holds back some medical students and trainees in medicine. Over twenty years later we are still talking about the ethnicity attainment gap.

Dr Anthea Mowat
Chair of the BMA's representative body
and the BMA's lead on equality and inclusion

What is the issue?

Differential attainment in medical training has been recognised for decades as an issue which holds back some medical students and trainees in medicine. In 1995 the BMJ reported on a study which found "significant statistical association between men with Asian names and failing clinical exams".

Over twenty years later we are still talking about the ethnicity attainment gap. GMC data shows a gap of more than 10% in the pass rates for medical exams between UK white and BME students, and over 30% between UK white and BME international medical graduates. This is seen in both general practice and hospital-based specialties" so that we do not single out any one College.

How is differential attainment being addressed?

The issues behind differential attainment are complex. We know this is not linked to academic ability, and is likely to be connected to the medical learning environment. Certainly, the data shows that there is no 'quick fix'. There has been a lot of national work to unpick the problem. The GMC has been working hard to understand the underlying causes including improving the data available to deaneries to help them pinpoint and address early problems. The GMC has also commissioned research into experiences of progression in postgraduate medical training. Health Education England has also recently put forward proposals on a targeted training scheme to support GPs who have not successfully completed GP training.

The BMA has long been committed to overcoming this challenge. Our 2014 symposium brought together the leaders in medical education and training, including BAPIO, to agree common principles to help tackle the problem. Since then, Dr Katherine Woolf's research has shown that this particularly affects BME students and trainees. The BMA is looking at this in more detail at a special event on Thursday 2 November. Dr Woolf will be presenting her research findings, and ahead of this has published a blog on the BMA's website about can be done to improve outcomes for minority ethnic and overseas-trained doctors.

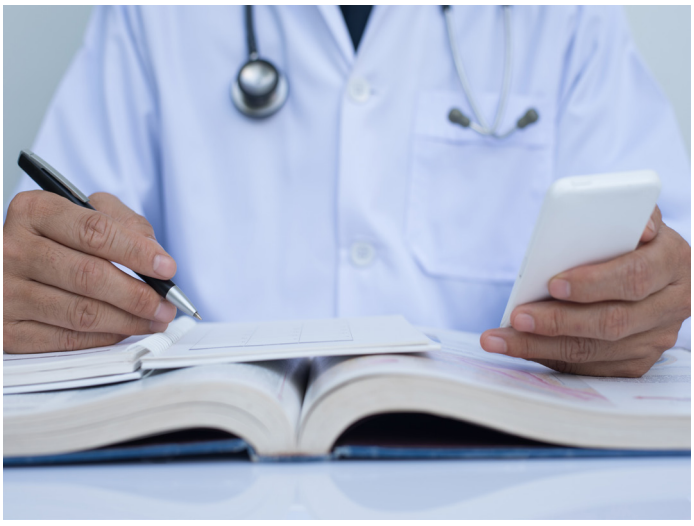
We'll also be highlighting what approaches can make a difference to individuals progressing through their medical careers. We are delighted that a strong cohort of BME students and trainees will attend our event to reflect their experiences - positive and negative from current training programmes. They will be joined by representatives from BAPIO, BIDA, the GMC, HEE, Royal College exams and diversity leads and deaneries.

Looking ahead

It doesn't stop there. We will be making a short film to capture the thinking, which alongside a summary briefing, will be published on our website. We're not letting delegates go away empty-handed – we'll be asking them to identify what they will do differently in their own organisations, and because we are a learning organisation, what more the BMA can do going forward.

We'll be continuing to talk to all the major stakeholders on this agenda. Only by sharing information and collaborating nationally and locally will we make a difference for current and future doctors. We enjoy regular, productive meetings with BAPIO and our new Chair of Council, Dr Chaand Nagpaul is looking forward to addressing this conference on Sunday.

Recent Workforce Race Equality Standard (WRES) data highlights only too clearly how widespread bias and discrimination is against NHS BME staff, including doctors. Our own research found that a third of Staff and Associate Specialist (SAS) doctors surveyed by our SAS committee had experienced bullying and harassment. We've responded with a major cross-organisational programme that aims to maximise the BMA's capacity to tackle bullying and harassment in the medical workforce. We're finding new ways to open up the medical profession and ensure students from all backgrounds are able to get into medicine. Only by overcoming these barriers in partnership with organisations like BAPIO will we make medicine a truly open, tolerant and inclusive profession. ❑



Postgraduate Programme
- *An opportunity to 'Learn & Earn'*

"MCh & MMed Edge Hill Postgraduate University Programme is a radical change in the postgraduate training in the British healthcare with a unique opportunity for British and Overseas doctors whereby trainees can work full-time in the National Health Service (NHS)"

Prof Raj Murali FRCS (T&O)
Programme Director
Edge Hill University, Lancashire

There is a radical change in the postgraduate training in the British healthcare. This has opened up a unique opportunity to set up clinical academic programmes for British and Overseas doctors whereby trainees can work full-time in the National Health Service (NHS) and enrol in an academic programme facilitated by a partnership between Wrightington, Wigan and Leigh (WWL) NHS FT and Edge Hill University (EHU) over a two to three year period. Successful completion of this programme leads to Master in Surgery (MCh) and Master in Medicine (MMed).

This Masters programme which has been delivered since 2008 initially in Surgery and has been introduced in medicine this year. The Orthopaedics and Otolaryngology (ENT) part of the programme is accredited by the Royal College of Surgeons of England.

The selected candidates are in full time employment and do the academic modules on a part-time basis.

The academic module has clinical and research elements:

a) Clinical research module: This includes two components: 'Critical Appraisal' module and 'Developing a Research Proposal'.
b) A dissertation:
c) Clinical modules: This includes Audit, successful completion of assignments and summative assessments.

Recruitment: There is an objective process with essential and desirable criteria followed by a structured interview and verification of the references. All selected overseas candidates have to successfully complete the IELTS exam with the expected overall score in each component to be eligible for GMC registration and Tier 2 visa through the sponsorship scheme. The sponsorship is obtained through Edge Hill University and WWL partnership scheme.

Training involves regular Assessments and with Clinical placements.

Clinical placements: The selected overseas trainee works for two to three years. First year is spent as International Training Fellow (ITF) focusing on generic aspects of patient care. The next two years focuses on improving the clinical skills with increasing responsibilities.

To complete the Mch/MMed programme the candidate is required to successfully complete annual appraisal, work place assessments and dissertation

There are twenty eight NHS trusts participating in the rotations in various specialities. Service Line Agreements (SLA) with WWL for employing trainees through this programme have been established. The clinical placements are tailored to the needs of the doctor.

Outcomes: Academic achievements so far include national and international conference poster and podium presentations, peer-reviewed publications, teaching qualifications, research fellowships, additional master's degrees and completion of membership and fellowship Royal College examinations.

At the time of publication of this article the programme has awarded over 100 doctors with MCh in various sub specialities, and has students registered in the following clinical specialities.

Medicine (leading to MMed): Interventional Cardiology, Respiratory medicine, Nephrology, Gastroenterology, Rheumatology
Anaesthesia (leading to MMed): Regional Anaesthesia, Intensive Care, Pain management
Psychiatry (leading to MMed): Child and Adolescent Mental Health
Paediatrics (leading to MMed): Gastroenterology
Surgery (leading to MCh): Colorectal, Minimally Invasive surgery, Surgical Oncology, Otorhinolaryngology, Otology, Hip and Knee, Upperlimb, Spine, Paediatric Orthopaedics, Trauma and Orthopaedics, Ophthalmology etc

Quality Assurance: This programme can sponsor doctors for registration with General Medical Council UK. http://www.gmc-uk.org/doctors/registration_applications/list_of_sponsors.asp

The Royal college of Surgeons of England has accredited the MCh (T&O) and MCh (Otorhinolaryngology) and the programme has the support of Health Education England, Greater Manchester Health and Social care partnership.

The programme also has the support of British International Doctors Association (BIDA) and British Association of Physicians of Indian Origin (BAPIO).

In addition, the dissertation is assessed by an external examiner and verifier to provide independent validation. The academic and the clinical leads constantly assess the programme to provide high quality clinical academic education. The clinical leads meet regularly which allows learning from each other to provide an improved educational experience to the trainees.

Benefits: Trainees: For the overseas trainees, this programme provides an opportunity to get engaged in clinical research simultaneously providing an opportunity to get involved in academic work, learn and understand the principles of clinical research and audit. For the UK graduates this programme provides opportunity to get involved in clinical research and obtain additional qualification without compromising their clinical work under the European working time directive (EWTD).

National Health Service: NHS is the 'crown jewel health system' in the world but with the current shortage of junior staff, this scheme provides an excellent supply of competent trainees who benefit from the best clinical training in the world and at the same time ensuring that the high quality health care is not compromised.

EHU/WWL: This is an excellent partnership which allows the university to have a tremendous impact on the postgraduate clinical training by providing the university module in a flexible way at the same time WWL also gains national and international recognition.

Conclusion: This innovative training model is a symbiotic association in providing high quality health care in the NHS in return for excellent clinical training to overseas trainees mainly from the Indian subcontinent to learn essential aspects of surgery and medicine including clinical governance and patient safety. This allows trainees to accomplish clinical research and to obtain postgraduate qualification from Edge Hill University facilitating a surgical or medical trainee to become a "complete" surgeon or physician with technical and academic skills commensurate with practice in any modern health care system. ❑

Ethnic minorities and public sector leadership roles

"Do new government data resources help bridge the gap?"

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In the United Kingdom in 2017, 87% of people are White, and 13% belong to a Black, Asian, Mixed or Other ethnic group. (1) The National Health Service (NHS) is the fifth largest employer in the world with almost one in five of its workforce being of black and minority ethnic (BME) origin. Overall, around 40% of doctors in the NHS are from a BME background, with a substantial proportion hailing from the Indian subcontinent such as British Association of Physicians of Indian Origin (BAPIO) members.

However, the NHS has been accused of failures to use the talents of people from ethnic minorities, after research showed they are badly under-represented in senior national and regional positions. (2) At the same time, evidence strongly suggest that BME staff in the NHS are treated less favourably, have poorer experience and less progression opportunities. (3)

Despite efforts to rectify the problem, far fewer people from BME groups chair NHS acute hospital trusts in England than would be proportionate to their numbers in the population. (3) Only 2% of NHS trusts are chaired by people from a black and minority ethnic (BME) background, versus 13% of England's population and 20% of NHS staff being of BME heritage. (2) People from a BME background make up just 4% of the executive directors and 7% of non-executive directors on trust boards, and they are also much less likely to be non-executive directors of trusts than white men. (2) Despite the large number of BME doctors in the National Health Service, there are substantially less than expected at senior leadership levels, for example at Chief Executive Officer, Medical Director or Medical School Dean level.

Of course, this does not solely reflect inequalities by ethnicity. While 80% of NHS staff are women, women make up just 28% of trust chairs, outnumbered three to one by men. (2) Moreover, similar trends exist by socioeconomic and educational achievement variables. (2) There are geographic trends also – a study examined BME progression in the health service in London and exposed the stark contrast between the city's demography, with 45% of the population and 41% of its NHS staff made up of BME people, and BME representation of only 8% of trust board members, and 2.5% of chief executives and chairs. (4) However, the picture is mirrored nationally, with BME representation also absent from the boards of some national NHS bodies. (4)

This picture exists throughout society and not just in healthcare. In October 2017, the UK Government launched its new 'Ethnicity Facts and Figures' website which will contain statistics relating to ethnicity in 130 different areas, including health, education, employment and the criminal justice system. (1) This service has been created to find information about the different experiences of people from a variety of ethnic backgrounds. It gathers data collected by government in one place, making it available to the public, specialists and charities.

The key findings uncovered by the audit include the fact that ethnic minorities are under-represented at senior levels across the public sector and not just in healthcare. The audit also revealed employment rates are higher for white people than for ethnic minorities across England, with a larger gap in the north (13.6%) than in the south (9%). Education attainment data also shows there are disparities between ethnic groups in primary school which increase at the secondary level. Chinese and Asian pupils tend to perform well whereas White and Black pupils are doing less well. Indian people in work were the most likely of any ethnic group to work in the highest-skilled occupational groups: over 1 in 10 were in manager, director and senior official roles and over 3 in 10 were in professional occupations.

There are countless NHS reports that have looked at this topic of the ethnic minority workforce and measures to tackle instiutional racism. Data reporting that BME communities are more likely to live in poverty and how the education system disadvantages BME students have been reported consistently for decades. The data does point to some relative successes for Indian students, which may reflect cultural values emphasizing the importance of education and developing skills. This in turn bodes well in terms of productivity and societal impacts including the next generation of healthcare professionals.

Having looked through the 56 page report and website, it is surprising that there are not more resources on this thorny issue (Table 1) and it does seem that some of the striking messages have been diluted down rather than wholly transparent. There are some healthcare resources, with collected summaries on physical and mental health, preventing illness, quality of care, access to treatment, and patient experiences and results. (5) However, it is not possible to regionalize or personalize to look further into each summary currently, which is surprising given that both Public Health England and NHS England both have existing ethnicity datasets. That said, the website is unique globally will be a permanent resource, with new datasets being added over time. A specialist unit, run from the Cabinet Office under the First Secretary of State Damian Green, will also consider and co-ordinate the government's work. So it's a nudge highlighting the societal gaps: I would encourage readers to look for themselves. (1)

Thinking back to the NHS, how

else can we bridge the gap? There have been some other small steps - the health service has introduced a mandatory Workforce Race Equality Standard requiring healthcare providers (including NHS and private ones) to demonstrate they are closing the gaps between the treatment and opportunities for BME and white staff. (6) For example, when the Care Quality Commission inspects healthcare providers, progress on these metrics is considered as part of this process. Embedding consideration of inclusion in organizational strategy need to apply the same approaches as they would to any other issue affecting patient care and safety.

Hence, healthcare leaders need to continue to listen to staff and patients, learn from the existing research and data, and adapt good practice from other settings. Implementing measures that work include outcome measures holding senior managers to account in order to reliably measure progress. A recent NHS report suggested that there should be a BME workforce network champion at executive board level to ensure collaborative work does take place, and a small proportion of trusts have examples of good practice including engagement with BAPIO. (3) Leadership, accountability and alignment with strategy are crucial to develop and sustain this agenda and shift the demographics to more closely reflect society, not just expressions of good intentions and values.

Data publication encourages public scrutiny across sectors and shows these inequalities exist across society and not just in healthcare. Whether public or private, employers are expected to interpret and analyse the data to understand its causes. Considerable work still needs doing: to quote the Prime Minister from the press release 'people who have lived with discrimination don't need a government audit to make them aware of the scale of the challenge.' This applies to doctors from ethnic minority groups (and BAPIO members) as much as the rest of the society – education and skills will provide some of the opportunities but nurturing leadership and systemic efforts to bridge the gap is key. In the NHS context, we must, from boards downwards and the ground floor of clinics and hospitals upwards, be clear why tackling ethnic inequalities is important: the loss of talent from an already stretched workforce, the impact on productivity and efficiency in healthcare, and, most important of all, impact on the care and safety of all NHS patients. ❑

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5. https://www.ethnicity-facts-figures.service.gov.uk/health
6. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

TABLE 1: AVAILABLE DATA RESOURCES ON ETHNICITY (OCTOBER 2017). (1)

Crime, justice and the law
Policing, crimes, courts, sentencing, prisons and custody

Culture and community
Arts, digital, museums, libraries, volunteering, transport, local area and neighbourhoods

Education, skills and training
Schools, exclusions, further and higher education, apprenticeships and where people go after leaving education

Health
Physical and mental health, preventing illness, quality of care, access to treatment, patient experiences and outcomes

Housing
Home ownership, renting, social housing, homelessness and housing conditions
Work, pay and benefits
Employment, unemployment, pay and income, benefits, business and the public sector workforce

Dr Pooja Arora caught up with Medical Women's Federation President Dame Parveen, an inspirational medical leader for a rapid fire question interview.

Dr Pooja Arora
MRCGP, DRCOG, MBBS, BSc Psych
BMA General Practitioners Committee
BMA GPC sessional subcommittee
Birmingham LMC Freelance Rep

Prof Dame Parveen Kumar, a stalwart in medical education, is the co-author and editor of the famous textbook Kumar & Clark's Clinical Medicine. This year marked the centenary anniversary of the Medical Women's Federation and to mark this iconic year BAPIO held its first Women's conference – Women in Leadership making a difference. I managed to briefly catch up with Medical Women's Federation President Dame Parveen for a rapid fire question interview. Prof Dame Parveen is an inspirational medical leader and in a time where most of the Royal Medical Colleges have women as their heads, I thought it was an ideal opportunity to learn her thoughts about women and leadership.

Which woman inspires you and why?

The first woman who inspired me was my mother who told me 'everything is possible' even as a woman.

What is the best and worst decision you have made in your life

Best decision – marrying my husband, who was also a doctor.

Worst decision – I am sure I have made several bad decisions over the years but I hope they were all rectified!

What was the organisational culture like 10 years ago for women and do you feel the NHS makes efforts to continue to improve the culture for this cohort

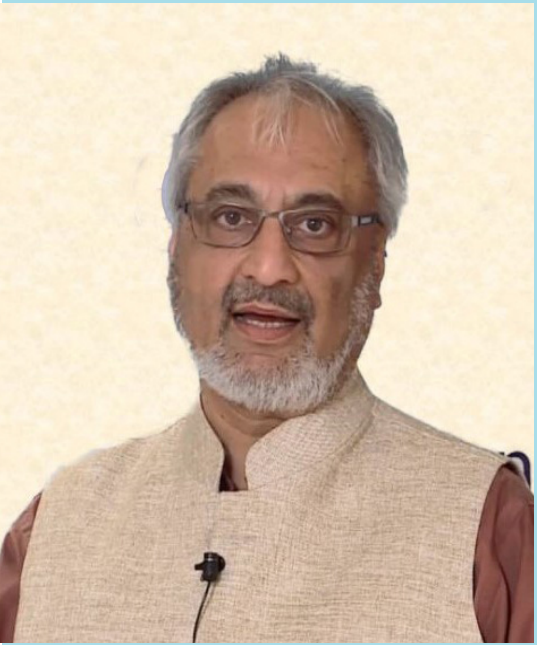
I'm going to base this answer on what it was like 50 years ago and what it is like now. 50 years ago, the NHS had a much nicer culture - junior doctors were well looked after, they worked in the same teams, management issues were sorted out by the doctors on committees, and there was more unity. I am sure this 'togetherness' of a happy team transmitted itself to the good care of patients. Today, although the patients are very well looked after, we are so tied up with guidelines, managers, computers, and bureaucracy that there is no spirit of unity or indeed generosity. People have no time, although the hours worked are shorter they are more intense. Doctors are on shifts and so there is no continuity as there was with the old firm system under a single consultant. Teams work in silos and do not look outward . Morale is therefore understandably down as the juniors feel dispirited and alone without the help of people they know. It is a great shame that the Doctor's Mess also disappeared as in times past we could chat to others in the same situation and dispel any unhappiness or anxiety. We would achieve more if we looked after each other and worked together. So going back to your question about women - there were very few then and many encountered problems. I was most fortunate as I had good mentors and supervisors, albeit , male ones. Today as there are more women in the healthcare system , they need to pull their weight and do as much as their male counterparts did. However, we do do things in a very different way. I look forward to when we don't have to distinguish between men and women as there should be equal parity.

What do you think the most significant barrier is to female leadership?

Females themselves. Women often think they can't do something as they lack confidence and often suffer from the 'imposter syndrome', whereas a man in a similar situation would have much more confidence. I wouldn't want women to be arrogant but to be honest about their abilities and have the confidence to apply for a job if they really believe they can do it!

What will be the biggest challenge for the generation of women behind you?

I do not believe that glass ceilings will be a problem. I would hope that women will stand on their own two feet working in the NHS with equity and as much equality that can be attained after factoring in the different genetic makeup. Women are already doing well and have a very bright future ahead! ❑



Stigma of mental illness: *A blight on society.*

"We are in uncertain times for the future of our NHS."

Dr JS Bamrah, FRCPsych,
National Chairman, BAPIO;
Consultant Psychiatrist, Greater Manchester Mental Health Trust.

It has become an established fact that BAPIO as an organisation strives to champion issues related to discrimination or inequality, and that sense it is important to remind ourselves that medicine has for generations shown an inability or disinterest in an age-old discrimination. And this is in relation to attitudes and behaviours towards those who suffer with mental illness, and indeed as I will demonstrate, those who practice psychiatry too. This is an indictment on modern day medicine, and while BAPIO itself cannot resolve the issue, this brief article will hopefully invite readers to see what they can do in their sphere of practice to eliminate this anomaly.

Definition

The term 'stigma' is derived from the ancient Greek word 'steizen' which was used to describe someone who was an outcast, such as a slave or a traitor. Today, it symbolises a prejudicial view from one sect of society, usually affluent, as being pejorative, and denying the existence or the rights of another vulnerable sect, as a matter of social expediency. In a sense, mental illness and stigma often go hand in hand.

The World Health Organisation (WHO) does not define stigma but acknowledges that it is a major issue. The mental health charity MIND describes it as 'a mark, a stain or a blemish.' Stigma is therefore 'an attribute deeply ingrained in individuals and societies whereby they discriminate, prejudice or humiliate certain people on account of a particular aspect of their physical or behavioural presentation, or both. They often act out their beliefs verbally, in writings, physically or any other ways of portrayal such as in the media to demean such people.

Size of the problem

It is impossible to compile accurate statistics on how common it is, and clearly some societies stigmatise more than others and there are often external events, such as a violent incident publicised in the media, which can cause random fluctuations. Within medicine itself, there have been generational trends too – remember the stigma of leprosy, tuberculosis, epilepsy, elephantiasis, Down's syndrome, even pregnancy and menstruation.

Mental illness and stigma

Whether we acknowledge it or not, mental illness is everywhere. By 2020, depression will be the single most important cause of disability worldwide after ischaemic heart disease (WHO). Mental illness represents up to 13% of the total burden of ill health worldwide, and in 2010, nearly 250,000 people (half the population of the City of Manchester) died of mental and behavioural disorders. Mental illness is the largest single cause of disability with at least one in four people experiencing a mental health problem at some point in their life and one in six adults with a mental health problem at any one time. Almost half of all adults will experience at least one episode of depression during their lifetime. Mental illness affects over 450 million people worldwide, of whom over three-quarters come from middle-income and low-income countries such as India. WHO estimates that mental health conditions account for 31% of all years lived with disability and are one of the four main contributors to years lived-with disability. Severe mental illness (SMI) such as schizophrenia and bipolar disorder are leading causes of chronic disability and death.

In the UK, about 3-5% people have a severe mental illness. At primary care level, 15-40% of patients will consult the GP with mental health problems with 7% of primary care consultations being for depression. Mental health problems are the third commonest reason for consulting a GP, yet 44-67% cases remain undetected by even the most motivated GPs.

Stigma is a common experience of those with a mental illness. One service user survey reports that 90% of those surveyed reported the negative impact of stigma and discrimination. Another survey conducted in Scotland showed that almost half the respondents would not want others to know that they have a mental health problem. It is unclear as to whether or not societal attitudes have changed towards mental illness. A MIND survey reported that there had been a shift of 8.3% in the last decade of positive attitudes, while the Scottish Social Attitudes survey carried out in 2013 showed that 47% of sufferers would not wish people to know about their illness compared with 44% in 2008, and 37% had suffered a negative impact of their illness compared with 23% in 2008.

It appears that women, those who suffer with a mental illness or know of someone who does, are more tolerant while older people are less tolerant. There are cultural differences too, with Asians being less sympathetic to severe mental illnesses but more tolerant of the 'neurotic' spectrum. World Mental Health surveys showed that 22.1% of participants from developing countries as opposed to 11.7% from developed countries felt stigmatised by their mental illness. In an American study, 63% of African Americans perceived depression as a sign of weakness and American Latinos were often viewing psychiatric diagnoses as being socially damaging. Indeed psychiatric diagnosis remains an important cause for stigma. The Scottish Social Attitudes survey found that 34% of participants were willing for someone in the family to marry someone with schizophrenia while 43% felt that patients with schizophrenia were likely to do harm to others against 10% of those who thought the same about depressives. An alarming 22% were not willing to engage in any way with someone with schizophrenia.

Clinical implications of stigma

Stigma can have a profound impact on people with mental illness. Several studies have consistently shown that those stigmatised are reluctant to seek help because of the sense of shame and isolation. There is ample research to show that particularly for serious mental illness delay in treatment has an adverse impact on the prognosis. Apart from a reluctance to seek help, compliance can also be affected. Patients might discontinue medication, leading to chronicity of their disorder. As stated above, mental illness is a huge burden on society, so the impact of poor adherence or reluctance to engage in treatment has direct economic consequences on the individual as well as the state. It is also a known

fact that patients who suffer with mental illness and a concomitant physical disease are reluctant to seek medical advice, and have worse outcomes; the reverse is also true that patients with a physical illness such as diabetes or cardiovascular disease and concomitant mental illness such as depression also have worse outcomes than those without any mental disorder.

Social implications of stigma

Those with mental illness might also suffer from labelling and discrimination in their daily routine, can become ostracised and isolated, suffer verbal abuse and can occasionally be subjected to unprovoked violent attacks. In fact a patient with schizophrenia is more likely to be harmed than to harm others, a fact that is either ignored or is little known. Employment is a key issue, with many fearing recrimination and therefore not declaring their illness or suffering ridicule or humiliation from colleagues or bosses when they do. Marital prospects especially for women and Black and Minority Ethnic can be adversely affected, and some severe cases of stigma can result in extreme forms of distress such as self-harm and suicide. Essential issues such as leasing safe housing and maintaining tenancy might be jeopardised and could lead to homelessness. Many can get caught in forensic and judicial services, where stigmatising and discriminatory attitudes are so prevalent to the extent of criminalising mental illness by the police. In their domestic circumstances, some will face rejection from family members and friends.

Professional attitudes

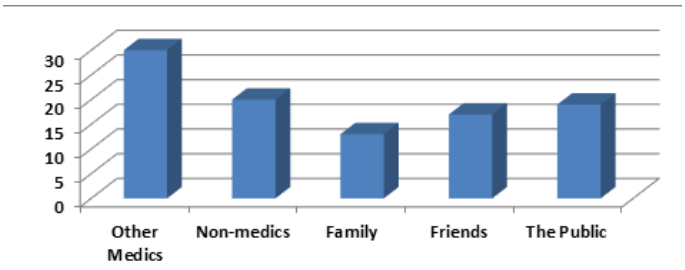
Stigma affects not just those who suffer mental illness but also professionals who are involved in their care and treatment.
In a recent survey of psychiatrists (see table below) attending an academic meeting I surveyed a sample of 34 psychiatrists of mixed grades and both genders.

Table 1: Questionnaire of psychiatrists on stigma

Question	YES	NO	NOT SURE
Is stigma a real issue?	100%	0%	0%
Have you been trained to tackle stigma?	32%	65%	3%
Should there be training to tackle stigma?	94%	6%	0%
Have you ever experienced stigma as a psychiatrist?	85%	15%	0%

The responses were startling, though of course this is a small sample of a circumscribed group. Nonetheless it does demonstrate that psychiatrists themselves experience stigmatisation as a result of their professional discipline, and furthermore that training in this area is lacking.

Figure: Who stigmatises psychiatrists?



The role of media

No article is complete without highlighting the impact of the media on portrayal on mental illness, and hence stigma of sufferers. It is not uncommon for criminals to be depicted both by the media and in films as being mentally deranged. The common member of public has the belief that all or most homicides and serious criminal acts are carried out by people with serious mental illness. The fact is that people with psychiatric illness are far more likely to be victims than perpetrators of violent crime. Despite this, the perception that mentally ill people are dangerous is increasing rather than decreasing. In part the increased stigmatisation might be due to the fact that previously these patients were incarcerated in asylums and therefore away from the media and public glare. Sensational headlines such as psycho, nutter, whacko, animal, mental, looney, etc. are fairly common while ECT tends to be a constant preoccupation and a subject of negative attention on both sides of the ocean, in Hollywood as well as Bollywood.

Good stories are very rarely written up or picturised. Films such as 'Maniac Cook', 'One flew over the Cuckoo's nest', 'Psycho', 'Silence of the Lambs' have just simply added to the inherent prejudices of the public. And in an Indian context, the Bollywood film 'Phobia' is a complete distortion of agoraphobia.

Tackling stigma

There have been a number of campaigns on tackling stigma by various organisations including the Royal College of Psychiatrists and MIND. While these are helpful, they do not appear to have had an overwhelming impact. Perhaps we might learn from the oncologists because where once cancer (or as was often said, the 'C' word) was so feared, it is now less so. To some extent dementia too has seen a paradigm shift.
In my view it would help if stigma were considered as a clinical condition. This would give it the priority it needs for doctors and other health professionals to identify it, challenge their own prejudicial belief, and raise their ethical stance towards it. And for this to happen, mental illness requires a complete change in attitude right from medical school. More exposure to psychiatry may not be the solution; any principled doctor must surely appreciate that it is unethical to discriminate against any patient on any count, and in this regard mental illness is no different. It is unacceptable in this day and age that there are health and social inequalities in patients with severe mental illness.

Three strategies would help root out stigma:

- LISTEN – Understand that most patients will feel stigma at some point and therefore give them time to ventilate their feelings and thoughts. Treat them with dignity and respect. Understand why they might behave in a certain manner, and try not to be judgmental.
- BELIEVE – If it is a patient's perception that they feel in a certain way, then that is how they feel. It is so important for them to be able to trust their doctor and to be able to confide in them, so give them a clear indication that you are willing to believe them about their experiences in relation to their illness.
- ACT – An active demonstration of ensuring patients can be comforted about their experiences will go a long way to reducing the impact on stigma, and this will influence many others too. Doctors have a wider and powerful role to educate the masses and the media. Resist the temptation at dumbing down those suffering or treating mental illness. And ensure that those who do that must be challenged as otherwise this gives them tacit approval to remain prejudicial

Summary

Stigma of mental illness is common and has overwhelming consequences for all patients. Doctors and other mental health professionals have a crucial role in tackling this and ensuring patients feel safe, comforted and unprejudiced in how we treat them.

https://www.time-to-change.org.uk/category/blog/stigma-and-discrimination
http://www.bbc.co.uk/news/uk-scotland-29988223
http://www.uniteforsight.org/mental-health/module7

PHP: A model of mental health care for doctors and dentists funding, devolution

Professor Clare Gerada MBE, FRCGP, FRCPsych.
Former Chair of the Council of the Royal College of General Practitioners 2010–2013.
Professional interests include mental health and substance misuse.

Introduction

There are complex reasons why doctors and dentists develop psychiatric problems in the course of their careers. Some of these are related to workload, unsocial hours, on call commitments and the pressure of being in the public eye. The taboo of mental illness spares no one it seems. Therefore it seems crucial that if these doctors can be treated within a confidential, purposefully designed service the outcomes for them will be much improved, and the NHS and in many cases their families, need not face the loss of these valuable individuals.

The NHS Practitioner Health Programme

Next year will be the 10th Anniversary of the NHS Practitioner Health Programme (PHP). PHP (www.php.nhs.uk) is a confidential mental health service for doctors and dentists. Initially only for London practitioners, since 2017 it has been rolled out across England, albeit outside London it is commissioned to provide care for general practitioners (www.gph.nhs.uk) only. All told, around 85,000 doctors can access the service, and around 700 do so per year. Why a specialist service is needed can be summed up by one word, stigma. Stigma of mental illness is endemic in the population, not least the medical profession.

Doctors suffer from patient, professional and personal stigma. Patients when asked, find it hard to believe that doctors can become unwell – be that with a physical or mental health problems, and if unwell that they should somehow heal themselves. This is a two-way process, between the interplay of projections between care-givers and patients and the 'phantastic' collusion, which occurs between the two.

'The helpful unconsciously require others to be helpless while the helpless will require others to be helpful. Staff and patients are thus inevitably to some extent creatures of each other'1.

As a profession, we are taught from early on in medical school to "just get on with it" to put our patients first and deny our own needs for theirs. This is facilitated by the hidden curriculum we are exposed too during our long and arduous training. I believe that during this training the individual under goes two major transformations – both to their sense of identity. One, to the sense of personal identity – in that personal and professional identities merge into a single "medical self" and the second to our group identity as our social, professional and family networks become increasingly narrow and we our group of belonging or group identity becomes aligned to the medical group. The rules of both (our medical self and group of belonging) include that doctors do not become unwell, there is a professional and personal stigma associated with this. That we continue well beyond what could be considered healthy or indeed safe to ourselves or for our patients. Presenteeism, that is coming into work when unwell, is more of a problem amongst doctors than absenteeism.

Stigma acts as an unconscious barrier which prevents doctors from seeking help. But there are also

more conscious and perhaps concrete barriers. Frequent changes of address due to training rotations makes it hard to develop a continuous relationship with a care-giver. Fear that disclosure of mental illness might impact on one's ability to practice as a doctor is always an issue – especially where the problems might involve an illegal activity such as addiction to drugs. Lack of confidentiality – especially so when one might work and live in the same area often leads to doctors hiding their problems.

Overcoming stigma is difficult, often campaigns aimed at reducing stigma back fire as they can further entrench the divide between the physical and the social. One recent survey found that over 90% of psychiatrists felt stigmatised by other medical professionals for being psychiatrists (Bamrah J, personal communication). So there are considerable barriers in the medicine which have to be overcome if mental health is be be considered at ar with phsycial illnesses. And while attitudes towards mental illness in doctors might be improving many doctors report adverse experiences. With nearly a third of all doctors reporting mental health issues, the task of self-reporting and seeking help remains a challenge for the medical profession2. For doctors, the creation of a confidential, supportive and expert can help overcome the many barriers doctors face and reduces the stigma associated with mental illness. PHP has been successful in allowing doctors to seek the help they need. Of the approximately patients attending PHP around 2/3rd have mental illness (depression, anxiety, burn out, PTSD) and around 1/3rd have problems related to alcohol and/or drug misuse (most often alcohol). All specialities have presented - though some are over represented (for example, GPs, psychiatrists and paediatricians). Those from the emergency specialities (doctors working in ITU, Anaesthesia, ED) are more likely to present with problems related to drug/alcohol. The age range is from early 20's to late 70's with the median age being 29-30 years. PHP has seen trends in the patents presenting to the service. For example, younger doctors are more likely to present with anxiety, drug misuse and adjustment disorder. Older doctors with depression, alcohol misuse and post-traumatic stress disorder. PHP supports doctors involved in complaints, regulatory or disciplinary issues (all factors which can lead to severe mental health problems).

Another good reason to provide a specialised service is the high suicide rates encountered amongst doctors. Indeed the rates in health professionals are higher than in the general population as many studies have found, so there is a case for widening the scope of such services. One study3 in England and Wales concluded that for the period between 2001 and 2005, the rate for health professionals, not just doctors, was highest among both men and women, while a US study4 showed that female doctors were at 2.5-4 times more at risk than women in the general population. Another US study5 estimates the risk of suicide amongst doctors between 28 and 40 per 100,000, more than twice that in the general population at 12.3 per 100,000.

Within PHP there are groups of doctors who either are underrepresented (for example surgeons) or where we have particular concerns about their special needs (for example, those whose primary medical qualification was obtained overseas). With respect to surgeons, whilst as a group they might have additional protective factors against developing mental illness overall their low rate of presentation might be to the additional 'macho' culture institutionalised within the speciality. Over 200 doctors whose primary medical qualification was obtained overseas, the International Medical Graduates (IMGs), have presented to the PHP. This includes those trained in Europe. This represents approximately 15% of the total patient population: The proportion of IMGs presenting more recently has increased to 20% of all attendees; Even at these figures the number is an under representation of the proportion of IMGs in the workforce. This includes countries across all continents. The number of International Medical Graduates is an under representation of the proportion of IMGs on the GMC medical register – and may suggest additional stigma associated with admitting to a mental health problem. As well as the barriers to care which non-IMGs have to contend with. IMGs have additional burdens. They may come from cultures where mental illness is such a stigma as not to be recognized and instead 'disguised' or sublimated into a physical health (somatic) disorder. There may be cultural barriers to taking antidepressants and receiving other treatments for psychological disorders. Some may fear that if they admit to having a mental illness that their license to practice will be removed and at worst they might face deportation. The IMG PHP patients have a lower percentage of addiction problems (11% vs 14%) but a higher proportion of doctors involved with regulatory issues (26% vs 15% of non-IMGs).

Irrespective of the presenting problem, age, gender or speciality, doctors who receive treatment at PHP tend to have very good outcomes. On independent analysis, doctors receiving treatment have improved outcomes in social functioning, health and well-being and return to return to work rates. For those with addiction, over 80% remain abstinent at 12 months to 5 years follow up, and only 4% relapse to problematic use.

Services such as PHP and others such as the BMA Doctors' Support Service enable doctors with mental illness to receive the care they so readily prescribe to their patients. This makes sense, as healthy doctors make for healthy patients2. Services such as PHP play an important role in the welfare of doctors. Nevertheless there are significant challenges in reaching out to some of the groups such as surgeons and IMGs. As this model of care becomes consolidated within the NHS, the positive outcomes will add to the growing awareness that effective treatments are available and accessible.

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Simon Wessely on the (trainee) psychiatrist's couch

Dr Devena Tyagi Sharma, ST5 General Adult Psychiatry, Merseycare NHS Trust

Sir Simon Charles Wessely is recent past President of the Royal College of Psychiatrists. He was appointed Regius Professor of Psychiatry, King's College, London and is the first ever Regius Chair in psychiatry in the United Kingdom.

He was knighted in the 2013 New Year Honours for services to military healthcare and to psychological medicine.

I conducted an interview with Sir Simon to find out more about what makes him tick.

1) Many congratulations on your appointment as Regius Chair. Tell me what that means? Is this a real or a virtual role?

It's the first time we have a Regius Chair in psychiatry anywhere in the country. They are medieval posts, going back six or seven hundred years, and appointed solely by the Monarch. The ancient universities - Oxford, Cambridge and two of the Scottish universities – were the only ones who used to get them until the whole procedure stopped 150 years ago. But then on the occasion of the Queen's Diamond Jubilee the idea was to firstly to inject some modernity into the titles (not just Greek, Latin, Moral Philosophy and Ancient History, not that there is anything wrong with that), and get some Chairs into the newer universities – new meaning anything founded after 1600! So there was competition around the UK, and dozens of universities applied for a total of ten Regius Chairs. As expected, London School of Economics got a chair in Economics, Imperial for Engineering and so on. And then King's College London – i.e. us – won with the first ever Regius Chair for Psychiatry. It's not an emeritus post which you get when you retire. So it's up to us what we make of it. Because it's the only one in the country, it's somewhat outward facing. It's not just for Kings, rather it is for psychiatry in general; promotion of psychiatry, promotion of research, engagement, dealing with other specialities, student health, issues like that. The scope is wide.

2) As past President of RCPsych it seems that you gained a lot of popularity. What would you say was the most defining moment of your Presidency?

It's hard to do a self-appraisal, because you are usually told what's not going well and not often about things that go well. It was fun and I think together with other College officials and staff we did do some of the things that I wanted to do but by no means all. As ever it was "events dear boy, events". So just as when my wife, Clare Gerada, was in the same role for the GPs, Lansley's Health and Social Care Act was unexpected and dominated everything, and of course turned out badly just as she said it would, I guess for me it was the junior doctors' dispute. We did our best, but in truth no one really emerged that well from it, and I am afraid many of the issues remain unresolved.

We did reasonably well in improving the public profile of the College, getting us the much more trusted voice and be out there, talking to people. I irrationally promised visiting every single medical school promoting psychiatry and I did carry out that promise and that was fun, supporting the 34 Psych Societies and getting to know our rail system rather better than I expected. Also on the plus side, RCPsych Congress continued to go from strength to strength. We took up on the issue of out of area placements with the Crisp Commission hopefully beginning the process of ending those problems. We also invested heavily in the Five Years' Forward View and we got most of the things that we wanted out of that, not all as you never do. It's always a compromise but we were up there and in there, and there was a lot of work done with government, the GMC, and others on various topics. I guess the biggest area where we haven't made an impact is recruitment. We may have stopped the slide, but it hasn't turned around.

Hopefully we have put things in place that will show benefits in the long run as it takes a long time to change things, so may be in next five years we shall see but on the foundation year for these medical school places, on exit exams, psychology degrees, and others, we did enhance activities across the universities and medical schools.

Another success was a big change in the way the College runs. I doubt many people though will have noticed this, but trust me, the system that Sue Bailey set up, and of which I was the beneficiary, with a separate Council and Board of Trustees, has been a real boon.

3) What would you have done differently?

Well, what I wouldn't have done differently (he says, ducking the question!) is the overhauled our communications strategy, which is far better than it was before. It's not finished – our website remains a good place to bury bad news, but that will change this year. Just as Sue handed over a much better governance structure, I am confident that I have handed over to Wendy (the new President, Professor Wendy Burns) a much better comms structure. And I think that ordinary members are aware that their college is more active publically. We have had an increase in our media reach, going up by 600% - people are turning to us for comments, not non-psychiatrists talking on psychiatric matters which has always upset me. Our social media presence has increased because of our juniors. Our influence in Parliament is far better than it was, it has improved considerably, we can measure that through the impact. Members like seeing that at least one of them is in the media or the Nine o'clock News and not always a critic. And I think that it does help morale with not just the Presidents speaking but our experts being out there, if necessary with support from the College. And in particular I am really pleased that we have a bigger range of voices, especially in age, and now more and more juniors are using social media so much successfully than greybeards like me

Overall, I do think that the College provides a pretty good service for members; we have the highest retention rate (98%) of any College. But where do I think we

didn't do enough? I think the issue of exams remains out there. We were caught unawares by the mental health act review – I suspect that will come up later. And there is still more to do with member engagement. And finally, well, its back to recruitment, recruitment and recruitment.

4) An issue that has really bothered me as a trainee is that I don't see any improvement in the issue of parity of esteem. Are we chasing a ghost or is this really achievable?

It depends what we mean, it's a vague word. Simon Stevens is quite scathing of it, I don't think it just about money. We get around 10% of the NHS budget, but we do 20% of the work, so obviously we should be given more in our budget, but not so that we get 50% of the whole thing, which would be parity with physical health, but doesn't really make much sense. it's also about lots of little things - access, relatives being able to get to the hospital, car parking, having nice facilities. There are some hospitals in London which have nice waiting rooms, and lovely artwork etc. whereas we are still stuck in some pretty poor accommodation. Parity is simply that we should have the same respect and dignity as the rest of the health service. What's good for one side of the road is good enough for the other (remember I work on Denmark Hill – we have the Maudsley on one side of the road, and King's College Hospital on the other) and if it's good enough for them, it's good enough for us is my motto. Likewise, parity means our colleagues and patients should not be abused by others as often they are. That's why we set up "Ban the Bash", and saw it hijacked by the GPs! (that's OK, I love GPs). Just as a trivial example, when I was doing my Grand Tour of every medical school, I was up in a Scottish University. I won't name it, but its big football teams are called Celtic and Rangers. I was speaking at the Psych Soc, which was being held off site. The reason was that the powers that be had ruled that psych soc activities were not relevant to the curriculum, and therefore couldn't be supported, unlike for example the meetings of the Surgical Society, who had free use of the facilities. This is what I mean by lack of parity. If the surgeons get a lecture theatre, or a nice coffee room to relax in, then we should too. Our space, our physical environment should be on the same level as the general hospital in the same area, that's what I mean by parity.

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5) Recruitment to psychiatry and managing the rising demand have demoralised many trainees and consultants. What role must organisations like the RCPsych play in dealing with these?

OK, we are talking about rising demand. I have to be careful here, because I have had my knuckles rapped over this. But let's take improving awareness. Really important, and it seems to be succeeding. That's great. We know from the latest studies that most people with mental health disorders now know that they have a mental disorder. Not all, but most. The problem is that they still don't seek help. So the barriers are more still around stigma, inadequate services and so on. And if all we do is raise awareness, which means more and more people seek professional help, but without increasing resources, well, the results might be longer waiting lists, and more, not less, demoralisation. So I did say that perhaps we should have started having mental health delivery weeks not awareness weeks. Otherwise you get burn out and early retirement adding to the stresses of a very stretched profession. That's exactly what has happened in general practice. Huge increase in work load and no increase in resource and a fall in work force with serious consequences. On the other hand, campaigns to reduce stigma are clearly still necessary, and even better are those campaigns to encourage people to find non-professional solutions – such as increasing their own social networks, as in encouraging volunteering in students and so on.

Ok, back to the workforce. We need to look at broadening the qualifications for entry into the profession – it's a scandal that a psychology degree is not seen as "scientific" for example. We should look at all alternatives, for example, some of the ways can be working with health education, and allowing more flexibility in careers, and go into a different part of psychiatry if they want to. Allowing that flexibility in careers, encouraging people to take on different roles, as you get more senior such as management, health education, or research, to give a variety of options to keep you going. We are lucky that it's still the case that the majority of psychiatrists are generalists – look at the mess that the surgeons and physicians have got themselves into with the almost total demise of the generalist. Then there are various measures of support that we have at the College for doctors including trainees in difficulty. It's not just about money and terms and conditions, but it will also include other bits like creating the support networks and guidance through difficult times. Structures at the moment seem to mitigate against that. Resilience is what you get from the social networks that stick with you. Sadly, we have many things in our system that can make you unresilient.

6) So mental awareness days must be abandoned! Would you revise your opinion in view of the comments you got?

It's not about abandoning such days, as I mentioned. It's a question not so much about awareness but reducing stigma so people can overcome those barriers to getting help.

It is a useful goal to have awareness that is accompanied with education and information, but public health campaigns can have downsides too, for instance if we push back the boundary of psychiatry to include normal emotional reaction such as grief, sadness, shyness etc. then we face criticism of being like the Americans and following the DSM broader diagnostic criteria. British psychiatrists are extremely keen that we do have boundaries and don't overmedicalise things to the point where we label every slightly quirky shy child as having Asperger's, or people stricken by grief as depression.

7) As you're aware BAPIO won a 'moral victory' in the Judicial Review of differential attainment of BME vs White candidates sitting the MRCGP exams. How would you support IMGs in achieving their full potential in the NHS? What role can BAPIO play?

BAPIO is playing a very important role already, but obviously, the statistics on success and exams is the same in almost all of the colleges. The hierarchy is there, and there are many reasons for it. The question is what you can do, one suggestion is to have differential standards. At RCPsych we did our own review of our own figures, with external people from Cambridge who concluded that it depended on where you graduated, and where you are from, as it did with the MRCGP exam. Now they have done a lot to ensure that some of the more obvious ones, that the breakdown of examiners reflected the breakdown of the people sitting the exam, which it does. GPs unfortunately hadn't got that, but we have a very diverse workforce anyway, so it actually wasn't that difficult. The Colleges have done very good work on that after the Judicial Review, to ensure that it reflected the people doing the exam. The next task is to ensure that the support IMGs had before the exam was adequate and to realise that some of the exam is about cultural sensitivities. If the situation were reversed, then I would fail in every country except the UK as I am UK born, and therefore it is getting easier. We need a systems approach. There's a lot of work going on supporting people and understanding some of the cultural differences that they are going to encounter, and of course in psychiatry those things are subtle but important. It takes several years before you start to see a difference. There is never any one thing, change takes time.

Take for instance the Mental Health Act. No-one is going to alter at the stroke of a pen signing off the Mental Health Act. That isn't going to miss the facts on the ground about discrimination, prejudice and representation of BME people who have been sectioned. I know that people with BME backgrounds get a tougher deal at school, more of them have problems and

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few of them get into the top positions in various fields. This is a big broad problem in society and even within BME not all ethnicities are the same, in fact far from it. But BAPIO does a good job.

In terms of what BAPIO should do that they are not doing, it is not for me to say, but I can say that they are very effective. They have a big reach, and particularly in psychiatry are very influential. I would say that one of the changes that BAPIO ought to play a big part in bringing together the different groups, because the more you bring together different groups, the more powerful you are. Look at how the Mental Health Policy Group, in which the College plays a leading role, works – when we hunt as a pack we are a very powerful lobby indeed, much more so than when we were divided, as was the case earlier in my career.

Also, being reflective is important so being able to put yourself in another person's shoes, and seeing what it is like sitting on the other side of the table gives a better perspective. It isn't essential but it is very much desirable.

8) Are you able to achieve a work-life balance?

I don't. Evidence suggests that it is not about having a work life balance but in fact the control you have over it. So, as you are the one controlling it, it's okay. The nice thing about having an academic career is that you have much more control over what you do. Job control is absolutely vital in satisfaction. And how you manage your work-life balance, so long as you are the one managing it, doing things like taking time off, if I want to, I'd go watch a Chelsea away game in Europe.

I don't have to tell anyone. I haven't filled out a holiday form since 1991, so I have control over these things. I think it's about controlling choice, it's not about how much you work and how much leisure you have, it's about whether you control what you are doing. This is not really a piece of advice; I don't give advice, especially not to younger people – other than reminding them never to invade Russia and never accept a police caution.

I think in terms of junior doctors, adding up the number of hours you work isn't the way forward. They may complain 'I worked 1 hour more than I should have done' etc. I don't think that's work-life balance. What is important in job satisfaction is all of the other things that contribute, it's about respect, control, choice, managing rotas yourself, and if you are working longer than you should be, then getting the rewards, which are not normally financial, rather they might be in terms of respect, having good facilities, ensuring you have proper, hot food when you are on call. That is what I think is work-life balance.

9) What's the secret of a good marriage for a high flying couple?

I suppose mutual respect, trust and support really. It wasn't supposed to be that way, but my wife was the one who encouraged me to run for (Presidency of) the Royal College, which hadn't been anything that I had been planning on doing. A part of it was the flexibility in careers. I was very much an outsider for sure, never been on Council, and then it was time for a change, to make space for others, don't cling on to your day job, let others develop and take over, and also give something back to my profession, and it worked out quite well. It was quite helpful that my wife was a bit of a back seat President, always telling me what to do, although it was occasionally necessary to remind her that 'It's my turn now'. She was incredibly helpful in some of the things that were going to go wrong, and also that I knew a lot of people in that world already through her and also through media stuff. So I was probably a bit better prepared externally than I might have been. That helped.

10) You're on a desert island, marooned on your own. A lamp appears next to you, you rub it and the genie offers you one wish. What would that be?

Probably a helicopter to get out of there. I would hate it there. I couldn't bear being on the infamous desert island, I don't like my own company that much, - I am very much a social animal. I'd absolutely die, because I like dealing with people, family, friends, people, colleagues. I hate it. I wouldn't even be able to look after myself. I can't even change a tyre on a bike. I can just about cook, although my family dispute it. Basically, once I had listened to my eight records, I would be finished.

11) What would be your last supper? And your last song?

Anyone who knows me would know that it would be Wiener Schnitzel. I was brought up on it by my parents, my father in particular, and I spent a lot of time on business, holidays, childhood, even now in central Europe, so it would be Wiener Schnitzel, with cucumber salad and a fine Austrian white wine. About my song, I don't know. I like classical music, my mother was a classical violinist, and I like jazz and if anyone listened to me on Private Passions (still available on BBC iplayer!), they will know I also like musicals, except for Les Miz. But I was brought up with classical music, and so I think the last piece would be the Adagio from Mozart's Divertimento No.13 in F for Wind instruments. If you have seen Amadeus, that's what's playing when Salieri realises that Mozart is the voice of God. . ❑

Should cannabis be legalised in U.K.?

"NO", says Dr JS Bamrah, Consultant Psychiatrist and explains: There is no scientific, moral or ethical justification for making cannabis a legal drug which can be made available on prescription, rather like antibiotics or antihypertensives. Just because it may have some medical uses does not mean that it is healthy. If that were the case then morphine and fentanyl would also be freely available.

The plant cannabis contains over 750 chemicals, including nearly 107 different cannabinoids. Some of these have been approved in some countries for therapeutic use, but due to the complexity of the compound it needs to be understood that the science on the use and abuse is not at all simple. Cannabis is highly addictive, this much is understood. It is estimated that 1:10 users become dependent. In the USA, nearly 4millon people are addicted to cannabis. And there are other serious implications. High users of cannabis are more predisposed to committing violent crime than non-users, and this has led Amsterdam to tighten up its regulations around legal use of the drug. Research in New Zealand shows that regular users of cannabis are 60 times more likely to use other illicit drugs than those who have never smoked cannabis. Cannabis itself is getting more potent; in the 1960s tetrahydrocannabinol levels, an active cannabinoid, were 1%, now they are up to 30%.

There are well documented psychiatric symptoms of cannabis. This is in part due to the rapid absorption of the drug – within ten minutes of the first puff it can be found in plasma – and also in part due to longer term effects. Intoxication, depression, anxiety, panic attacks, and disturbing paranoia are all witnessed in subjects, with the adolescents and the elderly being particularly vulnerable. Cannabis can impair motor driving skills in a dose dependent fashion, though no government has to my knowledge tackled this issue. Cannabis, like other potent analgesics, causes dose-related dependence as well as withdrawal symptoms.

Equally, there are also documented therapeutic uses of cannabis and its derivatives. These are control of nausea and vomiting, and weight gain properties. It is also used in peripheral neuropathic pain, such as in diabetes, and muscle spasticity, such as in multiple sclerosis (MS). For those who are unaware, cannabis is approved and available as a prescription as Nabilone (a cannabinoid) for nausea and vomiting and Sativex for spasticity in MS. The real impediment to identifying the true therapeutic value of cannabis is not that there isn't data on efficacy, tolerance or safety risks. On the contrary, it is that the views are polarised and furthermore academic research has not been conducted as in other randomised double blind controlled trials.

The picture around the world is a mixed one. Portugal was the first European country to decriminalise cannabis in 2001. Along with Netherlands and Norway, these three countries have legalised personal use of the drug. Australia, Croatia, Poland, the Czech Republic have legal provision for its use as a medicine while Turkey has gone further by allowing it to be cultivated as well as consumed as a medicine. Parts of the U.S. have legalised it, and Canada is very likely to make it legal across the country. In countries with permissive laws, cannabis clinics exploit every which way to attract custom. The Green Man Cannabis clinic in the U.S. boasts that its award winning strains are the finest on the planet and how its produce features in the two of the strongest strains, each with 26% activated THC, in the circular 'The Strongest Strains on Earth'. Many clinics offer discounts to disabled people, veterans, seniors and students, the very people who are the most vulnerable to effects and dependence on cannabis.

In U.K. cannabis remains an illegal drug with no plans to legalise it by this government who have clearly stated that "there is clear scientific and medical evidence that cannabis is a harmful drug". And so it remains a Class B drug within the meaning of the Drug Misuse Act, 1971. However, opponents such as the leader of the LibDems, Vince Cable, have mandated that they would legalise it because "there are serious side effects from driving it underground". Celebrities such as Richard Branson, Sting and Russell Brand have added their voice to the legalising lobby. My own view is that politicians and celebrities should stay out of this debate. The law as it stands is antiquated. Anyone found in possession can be sentenced to a maximum of five years imprisonment, an unlimited fine, or both. Anyone supplying or producing cannabis can be sentenced to a maximum of fourteen years imprisonment, an unlimited fine, or both. These laws are neither applied consistently nor are they enforceable. They do also criminalise those in whom cannabis confers certain medical benefit.

If this were a twitter debate, it would have a HASHtag #DOPE or #POT-ty. I am not in favour of WEED-ing it out, but legalising it is just a step too far. The right debate is the decriminalisation of cannabis. That's where our efforts should be concentrated. ❑

Personally, I don't believe it is just to criminalise patients for using cannabis to alleviate their pain. I hope you agree with me!.. Says *Dr Kailesh Chand, Former deputy chair BMA council,*

The oldest known written record on cannabis use comes from the Chinese Emperor Shen Nung in 2727 B.C. Ancient Greeks and Romans were also familiar with cannabis, while in the Middle East, use spread throughout the Islamic empire to North Africa. In 1545 cannabis spread to the western hemisphere where Spaniards imported it to Chile for its use as fiber. In North America cannabis, in the form of hemp, was grown on many plantations for use in rope, clothing and paper.

The earliest known reports regarding the sacred status of cannabis in India and Nepal come from the Atharva Veda estimated to have been written sometime around 2000–1400 BCE.

Cannabis has been restricted as a drug in the United Kingdom since 1928, though its usage as a recreational drug was limited until the 1960s, when increasing popularity led to stricter 1971 classification. Since the end of the twentieth century, there has been rising interest in cannabis-based medicine, and a number of advocacy groups have pressed the government to reform its cannabis drug policies.

Cannabis is widely used throughout the United Kingdom, by people of all ages and from all socio-economic backgrounds. It remains illegal for UK residents to possess or supply cannabis in any form.

Currently, cannabis is a Class B drug in the UK after being upgraded from Class C to Class B in 2009. This means both possession and supplying cannabis is illegal; if caught possessing cannabis you can get up to 5 years in prison and/or an unlimited fine, and if caught supplying cannabis you can get up to 14 years in prison and/or an unlimited fine . With the illegality of cannabis, many of the potential medical benefits, such as analgesia, cannot be utilised by those who may benefit from it .

Studies have been carried out evaluating the possible benefits of cannabis on a number of clinical conditions including chronic pain, nausea, AIDS-associated anorexia, multiple sclerosis, inflammation, and epilepsy.

Cannabis has been linked to various health problems such as depression, psychoses, cognitive impairment, addiction, etc. I accept,cannabis need to be investigated and analysed to help see if the benefits of legalising cannabis outweigh the negatives.

In 2012, a panel of MPs, as well as then deputy prime-minister Nick Clegg, recommended that drug policy be reformed, as the current policy does not adequately deal with the problem. But the idea, was rejected by then Prime Minister David Cameron.

In the UK we have cut off huge swathes of the population, branding them criminals and creating an underclass of people who no longer feel part of our society. Many of the violent criminal gangs owe their existence to the burgeoning, underground drug market. A sensible policy of regulation and control would reduce burglary, cut gun crime, bring women off the streets, clear out our overflowing prisons, and raise billions in tax revenues. For all these reasons, I believe that cannabis should be legalised. Cannabis could easily be regulated in the same manner that alcohol and tobacco are regulated and, more importantly, heavily taxed. The price could still be substantially less than current prices on the illicit market,and the revenue generated from the regulation could then be funnelled into education,NHS and other rehabilitation programmes. ❑

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