**Speech by Dr Mark Porter, Chair of BMA Council**

**Representatives, welcome to Edinburgh. I am both honoured and humbled to be standing before our great profession here today.**

**In this hall and beyond, the BMA represents 152,000 doctors and medical students, more than at any other time in our history. We have one of the most privileged jobs in the world. Helping patients and improving the health of the nation. It’s what we do. And it is often wonderful, inspiring and life-affirming.**

**But it’s easy to forget that. The NHS is struggling to cope with the double whammy of budget cuts and structural change. I feel as if we’re becoming a profession on the edge. And a medical profession on the edge, means a National Health Service on the edge.**

**More than 80 per cent of doctors in the survey we published today said they felt highly, or very highly pressured, at work. Almost 70 per cent said their experience at work was worse than it was a year before.**

**The survey puts figures to what all those of us working in the NHS know to be the reality. Two key conclusions stand out for me. Doctors are desperately trying to just deal with the sheer, unparalleled scale of demand on existing services. And we experience overwhelming frustration that we cannot achieve the changes and improvements that we can see are so necessary to deal with this pressure.**

**Therefore, colleagues, above all else, our task this week and in the year ahead is to make sure that the voice of the profession is heard. If it isn’t, the NHS will fail.**

**What happens when the government doesn’t listen?**

**So, let’s look at what happens when the government doesn’t listen. Let’s look at one of the great non-listening exercises of our time. Today marks 12 weeks since the Health and Social Care Act in England came fully into force.**

**We are still a long way from seeing the full impact of this unwanted legislation that does nothing to address the very real problems of quality, safety and financial constraints that we all know exist.**

**The government inflicted such unnecessary pain on the NHS that you can’t help wondering if it is one of the few public servants that the government wants to see pensioned off at 65.**

**By the government’s own reckoning, the NHS reforms have cost £1.6 billion; other estimates are considerably higher. And an immeasurable number of staff hours have been squandered. To achieve what?**

**Increased competition; even the government seems to have been playing it down recently. Integration seems to be the new mantra. Laudable, but how deep does that really go?**

**Taking the politics out of the day-to-day running of the health service; I think not. We only have to look at the government’s – and the opposition’s – recent response to the pressures on emergency medicine departments to see how well that’s gone!**

**Putting clinicians in the driving seat; we put this to the test: we asked doctors how many of them feel more empowered compared to a year ago. Do you know how many? Four per cent. Sixty-four per cent feel less empowered. For every doctor given what the health secretary promised the profession, fifteen have had it taken away.**

**At a BMA event earlier this month doctors told us about the barriers to them doing their job as well as possible.**

**‘It is not just about money’**

**‘It is not just about money,’ said one consultant. ‘It is how autonomy has been taken away. You spend time talking to managers who have no idea what you do - yet they are telling you what to do anyway.’**

**Is this what the government and those who run the NHS think freedom looks like? The Act might have seemed to collapse under the weight of its own misplaced ambition. Sadly not. Many of the threats it contained are still very much there.**

**Doctors involved in clinical commissioning are feeling undermined as NHS England tries to create a market for commissioning support services.**

**A market it acknowledges has risks when many buyers and sellers will be inexperienced. A market that creates further instability and makes it more difficult to retain expertise.**

**Would it not be better if NHS England focused on ensuring every CCG is able to get the high quality commissioning support that it needs, rather than creating yet another market?**

**Colleagues, as the Health and Social Care Act unfolds – or unravels – we will continue to hold the government to account at every opportunity.**

**While building a Byzantine system that no-one wanted, the government’s response to the real problems in the health service has been inadequate and divisive.**

**We are all painfully aware of the funding restraints on the NHS. It may have escaped the kind of swingeing real-terms cuts that other departments will suffer when the comprehensive spending review is published on Wednesday.**

**Hollow claim**

**But the claim that health spending is protected rings hollow when we face rising demand, new treatments to pay for, and virtually every NHS organisation is suffering year-on-year cuts.**

**The Nicholson challenge calls for a massive £20 billion of recurring ‘efficiency savings’ in England over the four years to 2015, and doctors in Scotland, Wales and Northern Ireland are reporting similar pressures from their governments. These ‘savings’ were meant to be reinvested back into the NHS.**

**Yet in the March budget the Treasury clawed back £2.2 billion unspent by the Department of Health. This is money that has been taken away from patients.**

**And rather than triggering planned and thoughtful efficiency improvements, the financial pressures are leading to far too many botched, quick fixes, including some drastic cuts in staffing which leave remaining staff spread far too thinly. How can we expect this to be safe for our patients?**

**At the Norfolk and Suffolk NHS Foundation Trust, for example, there are plans to cut one third of consultant posts and 40 per cent of SAS doctor posts, by 2016.**

**The BMA has been very clear that the safety and quality of services is under threat. The president of the Royal College of Psychiatrists has said patient care would be adversely affected. We simply cannot allow NHS organisations to behave like this.**

**Government may call this a cost improvement programme. I would call it cutting resources to and beyond the bone. The Secretary of State really does need a new thesaurus if he thinks efficiency is synonymous with cheap. Sometimes I’m afraid you get what you pay for.**

**NHS 111**

**It’s commonplace for GP out-of-hours service contracts to be awarded to the cheapest bidder. And this has continued with the new NHS 111 service. Only last week, there were reports of NHS 111 being launched in the West Midlands last March, despite the chief nurse of NHS Direct warning that it was unsafe.**

**If the NHS won’t listen to senior staff, it shows just how hard we have to work to make sure the voices of all clinicians on the ground are heard.**

**It all has consequences. This approach only adds to rising demand and makes it even more difficult to move patients through the system. To add insult to injury, the resultant chaos is then subject to a relentless assault.**

**The health secretary’s shameful recent attempt to blame accident and emergency pressures on GPs and their contract has backfired. It is absolutely clear from the figures that GPs are treating more patients, and with more complex problems. Thousands of GPs are helping to maintain and improve out-of-hours services.**

**All the health secretary has done is drawn attention to the lack of investment in urgent care, and the intense workload of doctors in primary and secondary care alike. I suppose we should thank him for helping unite the profession in denouncing his bogus claims.**

**Rather than clumsy and inadequate attempts to limit demand and access, the government should be doing more to reduce demand through better public health. But again in England, at least, the government is not listening.**

**The total cost of the harm caused by alcohol misuse has been put at more than £20 billion a year. There seems little doubt that a minimum price per unit, while not affecting most people who drink, would reduce alcohol-related admissions to hospital, and crime. We congratulate the Scottish government for taking a lead on this issue.**

**Tobacco packaging**

**Standardised tobacco packaging also seems to have been dropped in England. Can anyone explain why, without reference to vested interests? It’s a simple way of giving a clear, consistent message about the harm that tobacco causes. And the prospect of blackened lungs rather than seductive logos on the side of packaging was enough of a threat to consumption that the tobacco industry in Australia put up an almighty fight to prevent it. A fight, I am delighted to say, that it lost.**

**How about a new approach and legislating where it is wanted and needed? Action on limiting the harms of alcohol and tobacco would cost very little, would have widespread support, and would make a lasting impact on the nation’s health. Isn’t that what politicians are here for?**

**So how do we as a profession respond to all this? We MUST rise to the challenge. Even when we are deeply frustrated? We MUST get involved. Even with a government that doesn’t want to listen? We MUST speak louder.**

**It is, and always will be our responsibility to our patients to do our best for them, to improve care. That is why again this year an Ipsos Mori poll found doctors to be the most trusted profession. I am not saying it will be easy.**

**We are dealing with a government that showed a contempt and complete lack of interest in discussing fair pension arrangements, and was willing to impose this year’s GP contract in England, even though thousands of GPs warned them about the impact of numerous new targets diverting time and resources towards box-ticking.**

**Health ministers across the United Kingdom, we know the Treasury is on your back. We know there are many calls within government on the savings you can make, and that other departments view your budgets with envy.**

**Too much of the agenda of how NHS resources are being spent is still in the hands of managers. We need to take a leadership role, if we truly want influence.**

**This is a good example of where doctors can and must put ourselves forward. We will do this responsibly: we are willing to take on that leadership role. And yes, we are willing to take responsibility for decisions, even difficult and controversial ones, as long as we have been genuinely involved in making them.**

**It’s what we are already doing in our surgeries and hospitals. Every day, you will find doctors driving improvement in services, despite the barriers. Most go unnoticed by the wider public.**

**We’re already there, we’re already seeing what needs to be improved, and trying to do it. Civil servants and ministers are being sent work shadowing, (and I’d welcome any of them to my hospital), but let’s not forget the insights of the people who work in this environment every single day.**

**The year ahead**

**So, what can we expect to see in the year ahead? In the current financial context, any contract negotiations we might enter into, will be extremely challenging. Our instinct might be to just say no, and there may be good reasons for that.**

**But there are issues that we have to confront regardless, including about how we work best for patients.**

**For consultants this is 24/7 working – a prime example of the debate about achieving the right balance for patient care, and an already stretched workforce. Managing patient expectations against the reality of the current workforce capacity.**

**Like many doctors here, I feel personally offended by the terms in which this debate has been couched. Like many of you I work nights and weekends as well, at times when much of the private sector is fast asleep and ministers are tucked up soundly in their beds.**

**Let us be clear. We all want urgent care at weekends and evenings to be of the same high standards as patients can expect on weekdays. But the calls we sometimes hear for a Tesco NHS, full service, 24/7, are just ridiculous when the health service can barely afford its current model.**

**For junior doctors the issue over working hours rumbles on. The current limits on working hours have made hospitals safer for patients and any new contract must retain these vital safeguards.**

**But many of our members are still working 90-hour weeks and unrecorded hours, and they are rightly concerned about the impact this might have on their patients as well as themselves.**

**This was summed up for me last week as I read a blog comment from one of our junior doctors: ‘As I sit here waiting to go in for night shift number 6 of 7, I definitely feel it is unacceptable to work 7 nights in a row. I feel physically exhausted. [said the doctor]. I don't want medicine to be all that occupies my time but this is made exceptionally difficult by having to work 88 hours this week!’**

**A vehicle to improve care**

**And what about our GP colleagues? This year’s discussions on their contract must be the result of a genuine partnership with government. If governments will join us in common cause, the contract can be a vehicle to improve care, rather than one in which they perform a hit and run on general practice.**

**But nowhere is our involvement more important than in improving the safety and quality of care in the aftermath of the report of the Francis Inquiry. This is an area where it is not only government that should be listening. But we, the medical profession need to listen too.**

**Colleagues, I salute Julie Bailey, the founder of the Cure the NHS campaign. A woman of singular courage, who brought a measure of belated justice for those who had suffered at Stafford Hospital. She got herself heard, she stood up to obstruction and abuse. She led.**

**I want to assure every doctor and patient out there, that we, as the British Medical Association, will do everything in our power to help to ensure that a tragedy like this cannot happen again.**

**The government talks of a ‘safety first’ culture, of ‘zero harm’. The press demands it. The public don’t understand why it is not already in place. The reason why this culture does not exist is simple.**

**When someone puts safety first, as Sir Bruce Keogh did recently when he acted sincerely and responsibly on the data he received about children’s heart surgery in Leeds, they are subjected to a deluge of criticism.**

**Our duties**

**It is our duty as a professional body to take responsibility for our profession and promote the achievement of high quality health care. And it is all of our duties as individuals to have courage where this means upholding, to the highest standards, good medical practice in a safe environment.**

**If we have concerns, we must not be deterred by institutional boundaries. We must not be fobbed off by organisations that are better at protecting themselves than their patients. And we must not lose sight of why we became doctors.**

**We have a responsibility to bring in a culture of quality and safety across the whole of the health service. And nothing should get in the way of that.**

**We will work with government, with medical managers, with nurses and physiotherapists and with anyone else we can, to guarantee the protection of the patients in our care. But doctors must feel comfortable and safe when raising concerns. At present, we do not.**

**Many doctors express fear about the consequences, and this inhibits us from doing what we know to be right. The answer here is not to criminalise that fear, not to introduce an individual statutory duty of candour if you will, but to remember that for speaking up to be meaningful, employers must listen to patients’ and doctors’ concerns.**

**Employers must protect those who speak up instead of punishing them, as so often happens. This more than anything else will truly transform the organisational culture of the NHS.**

**What does leadership really mean?**

**Here again, we must be willing to lead, and think what leadership really means. Leadership is not just about giving strategic direction or leadership of a team, it’s in what every doctor does every day in the care of their patients.**

**Leadership by taking responsibility: a personal responsibility for the care of the patient as their doctor and as their advocate. We are privileged to be in a position to accept this responsibility and we must discharge it to the best of our abilities.**

**Leadership by example: in that we show to others that the care we give to patients is always our first concern, and by taking prompt action if we think that patient safety, dignity or comfort is being compromised.**

**These are often difficult and dispiriting times. I know many of us feel frustrated, stressed, even afraid for the future. It can seem like a leap of faith, even naive, when we pick ourselves up once again to get involved.**

**But we can make a difference. We are already making a difference.**

**Celebrate our successes**

**Achievements can be hard to come by, but we can learn from those we have. We saw off the threat of the South West pay consortium. Some employers chose to interpret their freedom as foundation trusts as being a way not to improve services, but to destroy negotiated national pay agreements.**

**This will not be the last we hear of this threat to the recruitment and retention of doctors and maintaining high quality care. We must be vigilant.**

**There was a positive relationship with governments and the GMC over revalidation, where some important changes were won that make the system more practical and achievable for doctors.**

**And we should always remember that for many of our members, the BMA is not a meeting in Edinburgh or a building in London but the practical support that they receive every day in every part of the country from our employment advisers and industrial relations officers.**

**Our medical students committee successfully fought governments on over-subscription to get a commitment that every UK medical graduate will have a place in the foundation programme this year.**

**Our staff, associate specialists and specialty doctors committee agreed joint UK job planning guidance with NHS Employers, reinforcing the place of these senior hospital doctors in practice.**

**We have launched ethics toolkits to help doctors in the armed forces and students and we have awarded hundreds of thousands of pounds in research grants.**

**In Scotland, we have a commitment from the government that it will work with us in developing medical leadership as it plans integration of health and social care.**

**In Wales, the BMA is working to ensure that planned legislation on organ donation protects donors’ interests while helping to meet a desperate shortage.**

**In Northern Ireland, where there is a major reconfiguration in progress, the BMA is ensuring members’ concerns are being heard in government about how it will work in practice.**

**For all these things, I want to thank every member who dedicates his or her time to the association and every staff member who works so tirelessly for our benefit. I am so grateful for all your hard work and effort.**

**Colleagues, we speak for a profession more diverse than ever before. And this is where we come to acknowledge our differences, to learn from each other, and to argue honestly and passionately about how and where we lead our colleagues.**

**But for all that might divide us, we should never forget that we have chosen to commit ourselves to a common ideal.**

**Colleagues, it is sixty-five years since the bold and beautiful experiment of the National Health Service came into being. We embrace its future as leaders, partners and listeners.**

**Let us show the government that we listen, and we must be listened to. That the NHS is more important than them, more important than us. And only when, we have no ‘them and us’, can the NHS hope to truly flourish.**

**Thank you.**