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PRIVATE HEALTHCARE EDITION

The Parliamentary Review

A YEAR IN PERSPECTIVE

Foreword

The Rt Hon George Osborne MP

Chancellor of the Exchequer

The UK grew faster than any other major advanced economy in the world last year, and is set to do the same again this year. Over the past 5 years we created two million new jobs. And the deficit – now 3.7% of GDP – is a third of what we inherited in 2010.

But all that progress could be put at risk if we don't continue with the plan that is delivering for the working people of this country.

Economic security is at the heart of that plan. It's not enough to simply eradicate the deficit – we have to reduce our unsustainably high level of national debt. At the Budget I published a revised Fiscal Charter that commits us to running a surplus in normal times to bear down on debt. In the autumn the House will vote on that charter and I hope it will mark the start of a new settlement for Britain's public finances.

Improving productivity – the amount that British workers produce for every hour they work – is the key route to making the UK stronger and families richer, and it's the greatest economic challenge of our time. We've set out concrete steps that we're going to take to improve the infrastructure, education and skills of the UK – and to make sure that this time it's a truly national recovery. Some of the biggest reforms include setting up a new roads fund to pay for the sustained investment our roads so badly need and introducing a radical new apprenticeship levy on large firms. We're also devolving even more powers to local areas over things like planning, skills and Sunday trading rules. And to back British businesses and encourage them to invest we're setting the annual investment allowance at £200,000 and cutting corporation tax to 18% by 2020 – making it the lowest in the G20.

The final part of the plan is to make sure work always pays, so at the Budget I announced a new national living wage, reforms to our welfare system and lower taxes for working people so we move Britain to being the higher wage, lower tax, lower welfare economy we want it to be.

> "Improving productivity is the key route to making the UK stronger and families richer, and it's the greatest economic challenge of our time"

Foreword

The Rt Hon Jeremy Hunt MP

Secretary of State for Health

I was delighted and humbled to be reappointed Health Secretary following the general election in May. It is a great privilege to serve the hundreds of thousands of doctors, nurses and other NHS staff working incredibly hard to provide high-quality care, and the millions of patients and families whose lives have been changed by their dedication and expertise.

Over the past 5 years, we have achieved a lot. We increased spending on the NHS in real terms every year in the last Parliament and, as David Cameron has promised, we will do the same in this Parliament too. We know that the strength of the NHS depends on the strength of the economy, and our long-term plan will ensure the stability and growth on which the health service depends.

Today there are 9,400 more doctors and 7,700 more nurses than there were in 2010. Last year, the NHS carried out over a million more operations than 5 years ago, and saw over six million more outpatients. And the service has embraced one of the biggest health challenges of our time, with more than 430,000 NHS staff undertaking dementia training to help them care for vulnerable patients.

But there is more work to do. Over the next 5 years, we must transform out-of-hospital care so that older and vulnerable people get the joined-up support they need at home and in their communities.

We must ensure that the NHS becomes a truly 7-day service, where patients know they will receive the same quality of care and treatment whether they fall ill on a Tuesday or a Saturday. I am delighted that David Cameron used his first major speech after the general election to announce plans to achieve this.

The NHS is facing serious challenges. We have an ageing population, increasing consumer expectations, and growing numbers of people who are living with long-term health conditions such as dementia and diabetes.

I am confident that with the increased investment we have committed, the NHS' own long-term plan that we are backing and, above all, the dedication and talent of frontline staff, we can rise to those challenges, and become the world's safest, most compassionate and best value health service.

> "We must ensure that the NHS becomes a truly 7-day service"

Review of the Year

The shape of the market

In his budget, the Chancellor George Osborne raised the tax on medical insurance premiums

It has been another tough year for the private healthcare industry, many senior figures gathered at the Private Healthcare Summit in June reported. A speaker from Bupa told delegates that the firm expected the overall market to shrink again this year. Private health analytics firm Laing and Buisson put the overall size of the private hospital healthcare market at a little over £7 billion in 2013 – £5.5 billion when doctors' fees are stripped out. And the bargaining position for the medics who perform the bulk of the work for the private healthcare industry could soon be about to deteriorate.

Evidence produced by the Competition and Markets Authority and alluded to in a subsequent hearing of the Competition Appeals Tribunal (CAT) earlier this year said the overall number of consultants in the system could soon reach record heights as new doctors were appointed to that grade. This coming glut of senior doctors, which it is estimated will add an extra £2.2 billion to the NHS paybill, was first predicted by the Centre for Workforce Intelligence in March 2012. There will be an oversupply of 20,000 hospital doctors by 2020, the centre warned.

This could signal the reversal of another long-term workforce trend that came to light in the recent CAT proceedings. A National Audit office report showed that overall the number of doctors doing private work had declined from 55% in 2006 to 39% in 2012. Part of this was attributed to higher medical insurance costs for medics, while the Independent Doctors Federation told the tribunal that lowered pay from insurers, particularly from BUPA and AXA PPP, plus the expense of running a private medical practice were putting off newly qualified consultants. In addition, the Association of Anaesthetists of Great Britain and Ireland said the supply of anaesthetists to private healthcare had also declined.

In April, the *British Medical Journal* reported that junior consultants were choosing not to enter private practice because of growing costs. The respected journal reported the comments of the director of a specialist medical accountancy firm at the British Medical Association's private practice conference in April this year. Ray Stanbridge told delegates: 'Many junior consultants are electing not to go into private practice because of the hassle of going into it, because of the costs, and because it's easier to work a session in a private hospital. We are starting to see as a feature, for the first time, something that is already prominent in the United States: doctors

having a second job in a private hospital.' He said the gap in practice sizes was widening. Smaller operations with incomes between £15,000 and £20,000 were starting to close down, while at the same time the number of private doctors earning over £500,000 a year had also grown significantly.

But the situation for private medical insurers was also potentially troubled going forward. In what *The Daily Telegraph* called one of the 'less anticipated moves' in July's budget, Chancellor George Osborne raised the insurance premium tax rate from 6% to 9.5%. The hike will take effect in November, and *Workplace Savings and Benefits* magazine said the move 'could cause employers to cut back on private healthcare provision'. The specialist publication quoted AXA PPP healthcare distribution director Chris Horlick telling delegates at the Pensions and Benefits UK 2015 conference that the rise could 'potentially make the provision of private medical insurance less affordable to many larger employers – at a time when many such employers need their people to be healthier and more engaged and productive than ever, and when pressures on the NHS are increasing'.

The conference also heard from a representative of consultancy firm Barnett Waddingham, who argued that the tax rise would only exacerbate a situation where the corporate private insurance market was 'unsustainable'. The company's head of wellbeing had posted in his blog in November 2014: 'With premiums for medical insurance increasing year on year at unsustainable levels, utilisation low on other health related products such as employee assistance programs and income protection rehabilitation, it easy to see how the UK health insurance market is broken.' He added: 'Many companies offer a wide range of health -related benefits to their staff yet, where it is available, employees will automatically direct themselves through medical insurance as they are usually left to their own devices to find their treatment pathway. This has left many companies in a position where they are having to budget for large premium increases while seeing no return on investment.'

The tax increase in the Chancellor's budget could push employers in the direction of setting up a healthcare trust to pay for employee healthcare costs, rather than face significant annual premium increases, some sources said.

Private healthcare may become less affordable for companies

Growth in the self-pay market?

Private healthcare providers said they had noticed a growth in self-pay work relative to private medical insurance over the past year. Meanwhile, research by Laing and Buisson showed that the overall proportion of the population with private medical insurance had stayed steady at 11%, but that this masked a decline in personal medical insurance and a growth in corporate or employer cover.

A report published by Bupa last year said: 'People with company-paid health cover are now the largest single group of independent hospital customers, accounting for an estimated 34% of patients, followed by NHS-funded [28%] and individual-paid private medical insurance [21%].' The report, *A Prescription for Growth*, said that since the abolition of tax relief for private medical insurance contributions

in 1997 individual customer numbers had fallen by a third.

Another study of the self-pay market, released in June by Intuition Communications, saw a range of data collected and players in the system interviewed. One interviewee told Intuition: 'Providers and insurers are continuing to see evidence of 'down trading' in private medical insurance policies and a growth in cash plans or defined benefit schemes'. Another said some customers were increasing their private medical insurance policy excesses to as much as £5,000 in an effort to reduce premiums, in effect making them self-payers for less expensive procedures.

But the study found significant optimism about growth in the sector. The report's introduction said: 'Two years ago, estimates on the scale of growth varied but most felt at least a double digit growth over the next 3 years was realistic. Commentators in central London believed the market could grow significantly more. This sense of optimism appears well-founded in that the self-pay market has grown – indeed providers are quoting double digit growth year on year as achievable and sustainable.'

Based on current trends and the size of the self-pay market, Intuition estimated the total value of the work could go from £600 million to £912 million by 2018, although the report acknowledged the actual figure was likely to be a little lower when slower growth in the north of England, Scotland and Wales were factored in. Growth in self-pay was around 20% a year in London and the South East, compared with roughly half that in the rest of the country, it said.

The authors said their interviewees put the growth in the self-pay market down to rising premiums for private medical insurance and reduced confidence in the NHS. They said there was a perception that 'private medical treatment is now perceived as less of a luxury and more of a lifestyle choice'.

Their survey of private healthcare providers said the most popular self-pay procedures, excluding cosmetic surgery, were orthopaedic and general surgery, eye surgery and scans. They also reported that there had been an 'acknowledgement' of demand management by the NHS in the specialities of orthopaedics, ophthalmology and gastroenterology. The market also expects to see a growth in self-pay oncology if the government restricts access to cancer drugs.

The report said that some private hospital groups were advertising their willingness to do work that the NHS has restricted as being of 'low clinical value', including varicose veins, hernia repair, some dermatology work and cataract surgery.

Providers also said there was evidence that NHS commissioners had started insisting that low-cost treatment options were exhausted before referring for surgery, and that this could be having an effect – giving the example of a patient who must complete a physiotherapy course before being referred for a joint replacement.

Private Healthcare is now 'less of a luxury and more of a lifestyle choice'

Providers told the Intuition researchers that 'Patients are now far more likely to consider self-pay as an option at the beginning of their pathway because they understand NHS constraints and may have lost confidence in the NHS to provide their elective surgery in a timely way.' They also said that news coverage of delays in treatment saw spikes in enquiries about self-pay work.

Other research points to the fact that self-pay patients might want significantly different kinds of services to those with private medical insurance. The Competition and Markets Authority's research as part of the regulatory action that has been ongoing for the past 4 years found that while self-pay and insured patients' primary reason for going private was a reduced waiting time – with three-quarters of both groups saying it was a factor – there was a significant divergence on the other factors driving them to seek treatment outside the NHS. While over half of insured patients cited greater availability of appointments and better comfort and quality of accommodation as inducements, only a third of self-pay patients thought the same thing.

The findings on reduced waits chimes with the release of a report by the Patients Association. The national body submitted 110 Freedom of Information Act requests to NHS hospital trusts, and found the most significant rise in waits had been for cataract operations, up from an average of 69 days in 2013 to 93 days in 2014. Knee procedures had the longest overall wait, the association's research found, and a regional breakdown showed the east of England as the worst-performing region.

Patient Association chief executive Katherine Murphy said: 'These findings should be seen as a wake-up call and spur commissioners, policy makers and politicians to take radical steps to improve the speed of NHS provision.'

The chief executive of the Association of Independent Healthcare Organisations Fiona Booth said she believed another factor in the growth of self-pay could be the increasing number of people who were self-employed, who were going private in order 'to get back to work as quickly as possible'.

Market moves

If the private healthcare market this year saw no developments as dramatic as last year's flotation of Spire Healthcare, there was still plenty of movement within the sector.

In July, the sale of the old Royal Masonic Hospital in Ravenscourt Park, west London, to Middle Eastern firm VPS Healthcare was announced. The company said it hoped to turn the building, which had been owned by the cash-strapped Imperial College Healthcare Trust, into a cancer centre and to be a pioneer in the private sector in offering proton beam therapy. Although proton beam therapy can be accessed through the NHS, there are no health service units that currently offer the service on a significant scale, and a number of patients are sent abroad for treatment each year.

The Grade II listed Royal Masonic Hospital has been closed since 2006 and VPS hopes to re-open it as a 150-bed facility in 2017, saying it will bring an extra 1,000 jobs to the capital. The investment was welcomed by mayor of London Boris Johnson, who said: 'This

Mr Miliband called for a cap on profits made from NHS contracts by the independent sector

Investments are being made into proton therapy as a cancer treatment

is a tremendous vote of confidence in London's thriving life sciences sector as well as the skills and talent of our amazing healthcare professionals.'

The 2017 opening date will place the new facility in something of a competition with the NHS and another private venture. In late July, two NHS organisations signed contracts with the equipment supplier and building contractors to build proton beam therapy centres of their own, one in London at University College London Hospitals Foundation Trust and another at The Christie Foundation Trust cancer centre in Manchester. The NHS expects the two proton beam therapy centres to be operational in 2018, and the government is investing £250 million in them.

Targeting protons at a tumour requires a cyclotron that is the size of an estate car and weighs the same as a Boeing 747. Much of the other machinery involved is considerably larger. The technology allows higher doses of radiotherapy to be delivered to a more precise area with fewer side-effects than traditional methods. Proton beam therapy is particularly useful for treating cancer in children.

The *Guardian* reported earlier in the year that Proton Partners International is planning a network of three centres offering proton beam therapy in the UK, also opening in 2017, with sites in Cardiff, London and Northumberland. The paper said the company had the backing of £100 million from institutional and private investors, and that NHS demand for proton beam therapy treatment abroad would reach 1,500 patients a year by 2017.

Proton beam therapy hit the headlines last year when the parents of Ashya King were detained by police after they defied doctors' wishes in Southampton, and took their child for the specialised treatment in Prague. In March this year they appeared in the media, saying their child had undergone a 'miracle' recovery.

In late July, the Competition and Market Authority (CMA) approved the acquisition of the Simplyhealth private medical insurance company by fellow insurer AXA PPP. In a statement, AXA's chief executive Keith Gibbs said: 'We were presented with an opportunity to significantly increase the number of customers we serve in the UK. We are delighted that the CMA has concurred with us that this transaction will be good for customers and good for the market, and can now progress to completion of the deal and a successful and smooth transition for Simplyhealth's PMI customers and employees. The acquisition will enable us to build on both organisations' deserved reputations for outstanding service and will enable us to offer customers an even broader range of services and support.' The acquisition will take effect from August, having first been announced in May.

Cover, the health insurance publication, reported that the smaller firm being taken over was planning to continue its pursuit of the 'everyday health' market, and had recently bought Care and Mobility Limited, a Midlands-based company specialising in mobility equipment.

It is now more than a year since Spire Healthcare's flotation on the stock market. In March this year, the company published its full-year results, its first set since its flotation in 2014. The firm's chief financial officer Simon Gordon said group revenue was up 12% to £856 million, and adjusted earnings before interest, taxes, depreciation or amortisation were up 6.1% to £159 million. The trends across its income streams echoed what other parts of the industry were reporting, with a small increase in its revenue from private medical insurance of 1.4%, a larger increase of 7.4% in the self-pay market and a still more significant growth in NHS-funded work of 27.3%.

The report saw chief executive Rob Roger write that, whatever the result of the election, 'the next government is likely to be able to fund only a fraction of the anticipated gap from increased taxation', and that by the financial year 2020–2021 there would be a funding gap and market opportunity of £35 billion a year. Despite Mr Roger's bullishness on the issue, last June *The Times* reported that the possibility of a Labour election victory had damaged the size of the Spire flotation.

In March, Ed Miliband said he would bring in a 5% cap on the profits that the independent sector could make from NHS contracts above £500,000. But the increasingly difficult operating conditions for providers and insurers have already prompted signs of closer collaboration between the two. In November, Spire and Bupa agreed prices until 2021.

NHS work carried out by the private sector

NHS-funded work is an increasingly important part of the workstream for independent sector providers. Analysts Laing and Buisson put the size of the NHS-funded market for work done in private hospitals at £1.28 billion. A graph produced by the firm at the Private Healthcare Summit showed a step change in the number of procedures carried out by private providers over the 10 years up to 2013–2014. The total had grown more than nine-fold in the period, from less than 50,000 in 2004–2005 to nearly 450,000 per year in 2013–2014.

But the commercial director of one of the largest hospital groups sounded a cautionary note. Peter Kahn of Spire Healthcare told delegates he was 'worried' about the sector's dependence on orthopaedic work – no small part of which now comes from the NHS.

The independent sector has increasingly looked to recruit senior NHS staff in an effort to better understand the market for NHS work. In December, BMI Healthcare appointed Jan Thomas as its new NHS commercial director from her previous role as strategy director for UnitedHealth UK. Before that, she had held a number of posts in the NHS, including roles within the former East of England Strategic Health Authority and Princess Alexandra Hospital Trust in Essex.

BMI's managing director of commercial, business improvement, technology and infrastructure Martin Johnson said: 'As the changing healthcare marketplace creates new challenges and opportunities, we are confident that Jan will be able to deliver a clear vision for the future that will allow us to foster relationships to further enhance our proposition as a key partner working with the NHS.'

David Hare, chief executive of the NHS Partners network

There is still nervousness in the sector about being seen to be moving into providing too much NHS-funded work. David Hare, chief executive of the NHS Partners network, the part of the NHS Confederation that represents the independent sector, responded to a piece in the *British Medical Journal* in December about the number of NHS contracts won by private providers. He said the total number rewarded was 'a tiny fraction' of those won by publicly owned providers, and that 'What matters to patients is being able to choose the best available provider and to ensure that local healthcare provision is good quality. With lower than average wait times for treatment, excellent levels of patient satisfaction and strong evidence on quality, the independent sector plays a small but important role in ensuring that the NHS meets the needs of all patients.'

Private work carried out by the NHS

Many well-regarded hospitals expect growth in private work to offset other costs in the organisation

Laing and Buisson put the total value of private work carried out by NHS trusts at £529 million in 2013–2014, and data from the annual accounts of NHS foundation trusts appears to have shown only a small growth in this work in 2014–2015. Nine London teaching hospital trusts were jointly responsible for £259 million of the NHS's private earnings in the past financial year, the NHS data show. The biggest single earner for the NHS is The Royal Marsden in Chelsea, a world-famous cancer centre that brought in £77 million in private earnings in the 2014–2015 financial year.

A report by Intuition Communications said: 'Despite the potential opportunities afforded by developing private patient services, the NHS has generally been slow to dedicate resource to this growing [private] market. However, we are now seeing a number of NHS trusts considering private patient services in the context of efficiency and income generation programmes and thus setting targets and allocating resource.'

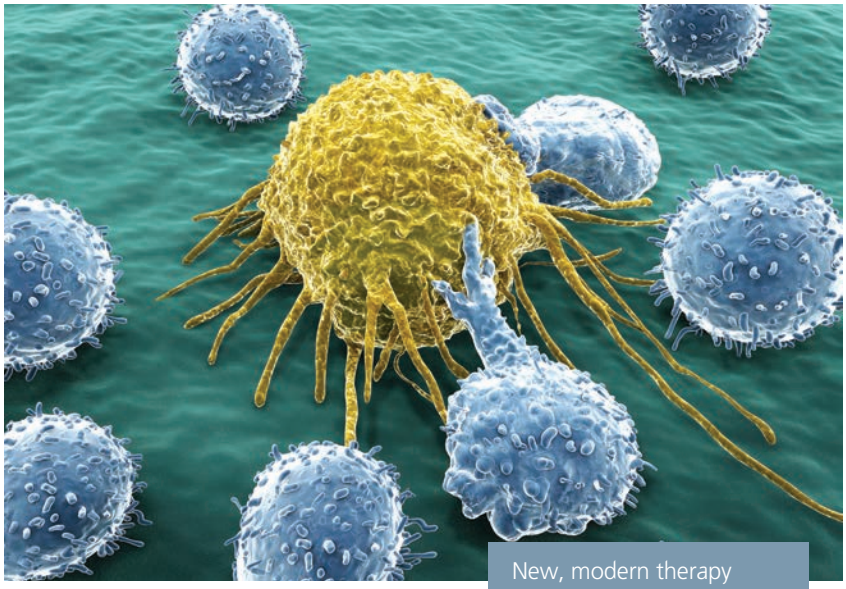
NHS organisations are increasingly looking to compete with the independent sector for work. Delegates from Chelsea and Westminster Hospital Foundation Trust at the Private Health Summit in June told delegates they were expected to deliver an 8% growth in private work to offset costs elsewhere in the organisation. The trust, which has a well-regarded private maternity unit, has earned nearly £37 million in private patient income over the past three financial years, its annual accounts reveal.

NHS organisations offering private patient units also have the advantage of a fuller range of support services on hand if something should go wrong during a procedure. Increasingly, private

patient units are run as joint ventures by a company and an NHS trust.

HCA International 's new chief medical officer Chris Streather, appointed in April this year, was previously chief executive of South London Healthcare Trust and managing director of south London's academic health science network. He told the summit that by the end of 2016 the company would be operating six private patient units in NHS hospitals. The company currently operates a blood and bone cancer treatment unit as a joint venture with University College London Hospitals Foundation Trust, plus joint ventures with Barts Health Trust, and Barking, Havering and Redbridge University Hospitals Trust on the London–Essex border.

Another joint venture saw a radiotherapy centre for private patients opened on the Guy's Hospital campus in October. At the opening of this facility, Sarah Fisher, chief executive officer of HCA NHS Ventures, said there were no private patient centres like



New, modern therapy centres are being opened

it in south-east London, and that the company was 'privileged to be working so closely with Guy's and St Thomas' who have had the strategic foresight to develop a major new facility. We know from our experience elsewhere, that our private patient units will generate substantial new funds for the NHS.' The firm also runs a private patient unit with the NHS-run Christie cancer hospital in Manchester, and an outpatient and day care centre.

Hinchingbrooke

April saw the end of Circle Partnership's involvement in directly running an NHS hospital. Management of Hinchingbrooke Health Care Trust was brought back within the NHS after 3 years of being run by Circle. The firm had asked to leave its 10-year contract shortly before an inspection report from the Care Quality Commission (CQC) was published. It had also been revealed in August 2014 that Circle had neared the £5 million limit of losses it was obliged to shoulder at the small district general hospital in Cambridgeshire. After this point, 'both parties must agree the basis for the continuation for the franchise', Circle's half-yearly report had said.

The situation had been complicated by a fractious relationship between Circle and the NHS's newly beefed up regulator, the CQC. After an inspection in September, the CQC ruled that Hinchingbrooke was 'inadequate' – the lowest of four possible ratings. The organisation was placed in special measures by the regulator after inspectors said they found evidence of risks to patient safety on one ward and a lack of paediatric cover in the emergency department and in theatres. The inspectors noted good care in the maternity and critical care units – but a war of words between

Accusations have been made of a 'stich up' against privately run NHS hospitals

the regulator and the firm had already begun.

The spat later saw *The Daily Mail* ask: 'The first privately-run NHS hospital victim of a stitch-up by opponents of business providing healthcare?' But after complaints from Circle about the inspection process, the hospital's grade was changed to 'requires improvement' following the re-inspection of two wards. The *Mail* reported this development with the headline: 'Official – first NHS private hospital WAS stitched up'.

In June, Circle chief executive Steve Melton told the Private Healthcare Summit that the 'ground had shifted beneath our feet' in Cambridgeshire after the deal to take over the hospital was signed in 2012. Mr Melton said the commissioners in Cambridgeshire had decided to take large amounts of money out of all the acute trusts in its patch, disadvantaging Hinchingbrooke disproportionately because of its size. He pointed out that Cambridge University Hospitals Foundation Trust had significant training and education funding while Peterborough and Stamford Hospitals Foundation Trust received a significant subsidy from the Department of Health to help it cope with the repayments on its private finance initiative deal. Mr Melton said this had resulted in an 'uneven playing field' and that the system leadership in the region had not moved fast enough to integrate hospital services with community care and GP surgeries.

Speaking at the same conference, one of the CQC's national professional advisers on the independent sector said the organisation was now taking steps to recruit more of its staff from the independent sector. Professor Chris Thompson told delegates he was aware of the 'risk of potential bias' when the commission assesses non-NHS providers, the *Health Service Journal* reported. He added that there would soon be a significant number of inspections of independent sector healthcare facilities because until then the commission had been focused on 'getting the inspection regime right in the NHS.'

In September, the CQC announced the first eight independent sector facilities that would be inspected. The most recent independent health provider to receive a rating following a CQC inspection as this publication went to press was The Harley Street Clinic in London, which in July received an overall rating of 'good', with 'good' ratings in the 'caring', 'responsive' and 'well-led' inspection domains.

CMA aftermath

The private healthcare industry is still dealing with the legal and regulatory fallout of a wide-ranging investigation and report from the government's competition authorities. 2014 began with the bombshell announcement from the Competition Commission that it would force the sale of some private hospitals to counteract what it saw as market dominance from the three main companies. But the year ended on quite a different note for the regulator's successor, the Competition and Markets Authority (CMA), when it was forced to admit mistakes had been made in its methodology, and some of the most radical measures it had ordered were withdrawn.

In April last year, the regulator had ordered HCA International to sell two of its hospitals in central London, either the Wellington Hospital together with its Platinum Medical Centre or the London Bridge Hospital and the Princess Grace Hospital. The CMA said that in the course of its investigation it had found that HCA faced 'weak competitive restraint from its rivals in central London', and that the prices it charged health insurers were higher than those charged by another London clinic.

The US-owned firm resisted the move, and made an appeal to the Competition Appeal Tribunal in May. HCA said the regulator had not given the company enough of a chance to comment on the data used in the price analysis, and that there was also an error in the calculations the report had relied on. The error concerned the confidence intervals for the results of

The London Bridge Hospital faced being sold

The CMAs methodology has been under scrutiny

the CMA's economic modelling. The firm's lawyers also argued that the definition of what constituted central London was arbitrary and that a forced sale was not a proportionate response.

In November, the CMA admitted the error, and said its order of a forced sale of the hospitals should be quashed. But it claimed that, while the modelling error had been a problem, the report's conclusions remained valid. The tribunal ordered that the decision be remitted back to the original inquiry group, chaired by Roger Witcomb, to make a new decision. HCA appealed this decision also, saying a new group should be set up by the CMA to make any further decisions.

In a judgement handed down at the Court of Appeal in May this year, Lord Justice Vos said: 'In the broadest of outline, HCA contend[ed] that the inquiry group of the CMA that handled the original investigation was incompetent, treated HCA unfairly over an extended period, and would be affected by either or both of apparent bias and "confirmation bias", the difficulty of persuading a decision maker that has once made up its mind to change its view.' But the Court of Appeal rejected HCA's request that a different CMA team be appointed.

In his judgement, Lord Justice Vos said: 'I do not accept that there was or is a risk of confirmation bias. The inquiry group is, as I have said, composed of highly experienced professionals. Mr Witcomb has made clear that the inquiry group will approach the process of remaking the decisions with an open mind, and I do not accept that the errors made in the past process give rise to an inference that he or his inquiry group or the case team would be affected by confirmation bias.'

The CMA is now continuing the work it started in January on what measures it should take as a result of its inquiry. Provisional findings are expected in September this year.

FIPO challenges the findings

The Competition Appeal Tribunal has already rejected two other appeals this year related to the private healthcare inquiry by the Competition and Markets Authority (CMA).

In June 2014, the Federation of Independent Practitioner Organisations (FIPO) challenged the CMA's finding in its final report that there was no adverse effect on competition arising from the exercise of buyer power by private medical insurers and the CMA's remedy requiring more publicly available information on consultant fees. FIPO's legal team had argued that a price cap instituted by insurers had meant consultants were unable to compete on price for private work.

The regulator's report had found that the four largest private medical insurers

together controlled 91% of the market, 'with Bupa having the largest market share of the private healthcare insurance market, at 39.5%. AXA PPP also has a large market share, at 25.5%. Third equal come Aviva and PruHealth, each with 13%.' But in a majority judgement, issued in April this year, the tribunal said: 'Price capping was not an inflexible rule, and to the extent that it was not rigidly applied consultants could clearly compete on price and quality.'

The CMA argued that the fee capping was not 'extensively and rigidly applied'. 'Even where price capping was applied, the CMA had carried out a careful investigation of consultant remuneration and had a proper evidential foundation for its view that consultants had not been 'screwed down' on price by the private medical insurers to such an extent that they would be unable to compete on price against each other.'

Costs were awarded against FIPO, and in June it was granted leave to appeal the tribunal's decision. In granting the decision, the Competition Appeal Tribunal panel chaired by The Right Honourable Lord Justice Sales said: 'In view of the differences between the majority and the dissenting member in the judgement, the appeal has a real prospect of success and, further, there is a general public interest in having guidance from the Court of Appeal as to the proper approach to be adopted to assessment of economic analysis in respect of such a challenge.'

Bupa currently control the largest share of the private healthcare insurance market

AXA PPP challenges the findings

The final report by the Competition and Markets Authority (CMA), produced in April 2014, found that there was not a significant negative effect on competition caused by the formation of consultant anaesthetist groups in some areas. Insurer AXA PPP said there was clearly potential for these groups of medics acting together to distort the market and that there was evidence of their collectively setting prices. Lawyers acting for the company said the CMA had failed to follow up evidence that anaesthetist groups had increased prices in some areas.

The Competition Appeal Tribunal registry's summary of the case said: 'The tribunal found that this was a case in which there was evidence pointing in different directions, in relation to which an overall evaluative judgement had to be made and where more than one alternative conclusion was rationally possible.' It went on to say: 'The CMA had tested the hypothesis set out in its theory of harm and rationally concluded that the price analysis showed "mixed results". The CMA's decision not to pursue its investigations at that point engaged its discretion and could not be impugned

AXA claimed there was potential for groups of medics to distort market prices

as irrational or in any way unlawful based on the application of judicial review principles.'

A study by Intuition Communications released in July asked providers how they thought the CMA study had affected pricing for self-pay patients. Half of respondents said prices had not changed, compared with 19% who said they had decreased and 11.5% who said prices had gone up. A little under half of respondents agreed that prices had become more transparent.

Providers 'strongly agreed' that patients would be better informed about choice of private healthcare once the CMA's recommendations were implemented and that competition would increase. Respondents were only slightly more likely to agree with rather than disagree with the statement 'our profitability will be reduced' after the CMA's rulings.

However, the competition authorities started collecting pricing information on the private hospital industry in 2007, a recommendation from the CMA that is being implemented with regard to improving the transparency of pricing and quality information. The Private Health Information Network has now been appointed as the 'information organisation', to ensure that care providers supply publicly accessible data within 2 years on surgery outcomes by individual consultants.

Fiona Booth, chief executive of the Association of Independent Healthcare Organisations, said in a statement after the Private Health Information Network was appointed: 'AIHO welcomes any development which informs patient choice. The sector is aware of the need for greater transparency, and is publishing a great deal of patient- and clinician-centred data.' The sentiment was widely shared at this year's Private Health Summit.

The CMA's 2014 report is due to be reviewed in 2017. The legal proceedings

and appeals may have concluded by then, or there may be further challenges to Mr Witcomb's next report in September. Either way, the industry will have faced a decade of increased scrutiny, challenge and legal battles.

It remains to be seen whether the CMA will revisit its most contentious orders: the forced sale of hospitals. The last time this was ordered the then BMI Healthcare boss and the company's former legal counsel Stephen Collier said the decision was 'bizarre' and that the sales would do nothing to lower costs or increase competition. And Mike Neeb, chief executive and president of HCA International, said the commission 'threaten[ed] unfair and unjustified measures'.

Monitor and Spire

Over the past financial year, Monitor completed its year-long formal investigation into a complaint from private hospital group Spire Healthcare about the commissioning of elective services in Blackpool. In October 2013, Spire had alleged that Blackpool and Fylde and Wyre Clinical Commissioning Groups (CCGs) had tried to inappropriately affect patient choice in the area.

In September 2014, the NHS competition regulator rejected Spire's accusation that patients had been diverted away from its Spire Fylde Coast Hospital and towards Blackpool Victoria Hospital, part of Blackpool Teaching Hospitals Foundation Trust. But it did conclude that 'Commissioners in the area were not making sure patients were offered a choice of hospital for routine surgery

Monitor completed its investigations into claims of inappropriate direction of patient choices in Blackpool

Jeremy Hunt announced that Monitor would be merging with the TDA

and were failing to ensure patients had information about the different hospitals available.' Monitor also said it was not satisfied with the Blackpool CCG's plans for ensuring choice and competition would be offered and properly publicised.

The CCG's chief clinical officer Dr Amanda Doyle made public her dissatisfaction about the basis of Monitor's assertion, issuing a statement: 'It is somewhat concerning that in their search for evidence to demonstrate whether choice was promoted and offered in GP surgeries, not a single GP, practice manager or patient was spoken to by the investigating team, nor was a single practice visited. Placing the burden of proof on CCGs in this way causes unacceptable pressures in terms of both cost and administration.' The regulator later said it was satisfied with the plan Blackpool CCG had agreed.

The private sector will soon be referring this kind of case, involving NHS services and patient choice legislation, to a different level. In June, health secretary Jeremy Hunt announced that he would be merging Monitor with the regulator of non-foundation trusts, the NHS Trust Development Authority. Where Monitor's cooperation and competition will sit in the new system was not clear as this publication went to press.

Ophthalmology

In July, the Competition and Markets Authority (CMA) fined a membership organisation representing private consultant ophthalmologists £500,000 for breaking competition law – the first time competition law enforcement action has been taken against doctors in Britain.

Consultant Eye Surgeons Partnership (CESP), which represents 38 limited liability partnerships and their 200 consultant members in Britain, admitted to a number of infringements. The (CMA) said these breaches dated back to 2008, and included CESP recommending that its members refuse to accept lower fees offered by an insurer, and that they charged insured patients higher self-pay fees.

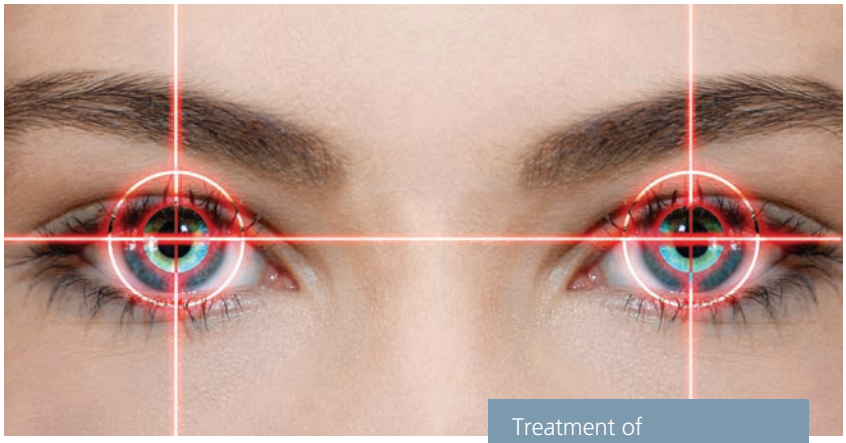
CESP also circulated to its members detailed price lists for ophthalmic procedures, including cataract surgery, to be used in negotiations with insurers. The CMA said: 'These collectively set prices did not pass on lower local costs (such as cheaper hospital fees) and made it harder for insurers and patients to obtain lower prices.' According to the CMA, CESP also admitted it had 'facilitate[ed] the sharing of consultants' future pricing and business intentions such as whether to sign up to a private hospital group's package price, which enabled members to align their responses.' The £500,000 was discounted by £75,000 because CESP agreed to cooperate with the CMA.

CESP has pledged to implement 'a comprehensive compliance programme', which the authority said was 'a positive step ensuring CESP Limited and its members avoid breaking competition law in the future.' Consultant ophthalmologist David Etchells was appointed as CESP chair along with a new board of consultants last year.

The next stage is for the CMA to review the programme, and if it is found satisfactory the fine will be reduced further. A decision was due in August as the *Parliamentary Review* went to press. The CMA's senior director of anti-trust enforcement Ann Pope said: 'This is the first time formal competition law enforcement action has been taken against medical professionals in the UK. This case demonstrates the CMA's commitment to taking action in specialised and regulated sectors, including the professions, and makes it clear that membership organisations and their members are not outside the scope of competition law or its penalties.'

In a limited statement published on its website, the membership organisation said: 'CESP has cooperated with the CMA throughout its investigation and is taking steps to ensure that its members and staff are fully aware of the requirements of competition law.'

The result of the CMA investigation was welcomed by the private medical insurance industry. Commercial director at AXA PPP Healthcare Fergus Craig told *Cover*, the health insurance and protection market magazine: 'The ruling is good for patient protection and welcome vindication of the precept that professional membership organisations are not above the law. We further welcome CESP's acknowledgement of its wrongdoing and commitment to putting into place a comprehensive competition law compliance programme to ensure that it does not infringe competition law again.'



Treatment of ophthalmology has decreased in price, with the benefits often being lifelong

Senior sources in private healthcare told Intuition researchers putting together a report on self-pay that: 'Ophthalmology is an increasingly competitive market with specialist ophthalmology providers competing in the wider surgical market. This is helping to make prices more competitive through better pathways and efficiency.' Ophthalmology is a specialty where the cost of treatment has declined and was increasingly popular as consumers saw the 'lifetime benefit for one off cost (e.g. cataract surgery or laser sight correction)' treatment, they said.

The private ophthalmology industry also pointed to evidence suggesting NHS rationing of cataract surgery, which could also have helped to drive demand for work from the independent sector. The Consultant Eye Surgery Partnership pointed to research from health analytics firm Dr Foster indicating a 'gradual decrease in cataract surgeries from 2009', suggesting that referral thresholds for NHS work have been raised.

CESP said in a press release: 'It is now likely that those that have qualified for treatment in the past may not be eligible if they wished to receive treatment now. Many people would have to wait until their condition deteriorated.'

Canterbury Skin and Laser Clinic

The first specialist private photodynamic therapy centre in Kent

Dr Mark J. Hudson-Peacock, Consultant Dermatologist

There has been both a huge increase in those seeking advice and treatment for problems relating to the skin and a significant change in the way that cosmetic skin treatments are carried out and monitored. Unfortunately, however, there has also been an increase in those with minimal training and experience setting themselves up as so-called 'experts' in the field. Consequently, there is much confusion among the general public about what treatments are available, and a disturbing variation in the quality of the advice and treatments being given. This makes it all the more important that well-managed clinics are established to meet the demand for services that cannot be obtained from the NHS.

At the Canterbury Skin and Laser Clinic we strive to provide high-quality advice for all skincare needs, whether purely cosmetic or arising from a medical condition, to all those who seek our help, whether through GP referral or self-referral.

Back in 2002, through our own research, my wife, Dr Alice Hudson-Peacock, and I realised that there was a lack of facilities where patients could obtain a comprehensive dermatological assessment and treatment in the same place. We created a vision of a new clinic that would work as a dermatological and cosmetic skincare 'centre of excellence', offering something not provided in either private hospitals or the NHS. We wanted to provide a more focused and complete service covering all areas of skincare, from beauty therapy to traditional medical needs, and look after the complex needs of our patients – all in an environment that is fit for purpose.

ABOUT THE CANTERBURY SKIN AND LASER CLINIC

- Established 2003
- East Kent's only dermatologist-led specialist skincare centre
- Treats all dermatological diseases – there are more than 2000
- Provides specialist laser treatments and surgery, counselling and a full beauty therapy service
- Addresses medical and cosmetic problems
- More than 5,000 consultations and treatments carried out annually
- First specialist private photodynamic therapy centre in Kent (established 2003)
- First Ultroid treatment clinic in the UK (established 2013)

Drs Alice and Mark Hudson-Peacock created a vision of a new clinic that would work as a dermatological and cosmetic skincare 'centre of excellence'

> "We maintain our high levels of care through continuing professional development and constant review of our practice"

The Canterbury Skin and Laser Clinic, now in its twelfth year, was established and continues to provide a very high level of dermatological and skincare advice and treatments. All aspects of skincare are addressed, from simple beauty therapy needs to advanced aesthetician-led care with chemical peels, medical microdermabrasion and laser hair removal using state-of-the-art equipment. Alice and I look after the more complex issues, from both a cosmetic and a dermatological perspective, including various laser and intense-pulsed-light treatments, prescriptions and complex surgery for various skin concerns, including skin cancer.

We are proud to have opened one of the first such clinics in the UK headed by a consultant dermatologist. We maintain our high levels of care through continuing professional development and constant review of our practice, aided by the regular feedback we obtain from our patients through questionnaires.

We strive to improve what we provide year on year. The team we have built around us aims for excellence in all that we do. We work with the highest integrity in providing the best care we can through integrated and multidisciplinary teamwork, both safely and effectively, and following appropriate fully informed consent – all key ingredients for successful working. Evidence-based practice carried out by well-trained individuals using the best equipment in an environment that is fit for purpose leads to the good care that we provide to all those who come through our door.

As a forward-looking clinic we have always looked to provide new and innovative treatments prompted by evidence-based research. Canterbury Skin and Laser Clinic was the first clinic in Kent to provide private photodynamic therapy for pre-cancers and some superficial cancers of the skin, laser hair removal and tattoo removal, laser treatment for birthmarks of different types and other sun-ageing signs. Alice and I were the first to provide a complete advice and treatment service for those with cosmetic needs seeking either non-invasive or minimally invasive treatments for all skin-related concerns (including pigmentation, thread veins, and lines and wrinkles) all under the same roof, together with our specially trained aestheticians and nurses. We are proud of what we have achieved, but the challenges and ever-increasing demand for newer treatments mean we still

» TERMS EXPLAINED

Photodynamic therapy – a treatment using a combination of light, oxygen and a photosensitising chemical to specifically target abnormal cancerous or pre-cancerous cells.

Laser (Light Amplification by the Stimulated Emission of Radiation) and intense pulsed light (IPL) – techniques for treating different skin-related problems using the ability of certain skin targets (specifically blood, pigment and water) to absorb light of a certain wavelength and to become selectively damaged.

Medical microdermabrasion – essentially a 'sandpapering' process that removes the outer layer of dead cells of the skin.

Coloproctology – the medical specialty concerned with diseases affecting the anus and related area.

have to stay on top of what is new and maintain our knowledge and skills to be able to continue to provide the best care we can.

Introducing Ultroid to the UK

As a dermatologist I have maintained an interest in pruritus ani (itchy bottoms), which can have many causes, including haemorrhoid disease. So when a friend of mine, Mr Graham Bason, asked me to look at a new treatment for haemorrhoid disease from the USA, I was more than ready to do so. Having carried out my own due diligence on Ultroid, I was struck by the lack of complications and apparent ease of use of the technique in an outpatient setting. The technique is uncomfortable rather than painful for patients, with no need for anaesthesia and no preparation, and patients are able to go back home or to work straight after treatment.

After being trained in the technique, we set about introducing Ultroid to the UK, with the first clinic being based at the Canterbury Skin and Laser Clinic.

We presented to NICE in Manchester in February 2013: there was significant interest based on the safety, efficacy and the potential for large savings for the NHS. We collected and analysed all the data from my first 100 patients treated in the UK, and the results were compelling. These data were presented to the European Society of Coloproctology (ESCP) in Barcelona in September 2014.

Our biggest challenge was to reach those people who mattered: the patients and the doctors. Our website was developed and a programme of regular advertising implemented. To bring Ultroid to the specific attention of relevant doctors, we had a stand at three medical conferences during 2014: the Association of Surgeons of Great Britain and Ireland meeting in Harrogate, the Tripartite Colorectal meeting in Birmingham and the ESCP meeting in Barcelona. In this way Ultroid was introduced to many surgeons. From these contacts, I have trained a number of doctors to carry out Ultroid treatments in different parts of the UK, thereby creating a network of clinics to give patients easier access to this safer treatment option. We are now well placed to meet the increasing demands for Ultroid following NICE approval.

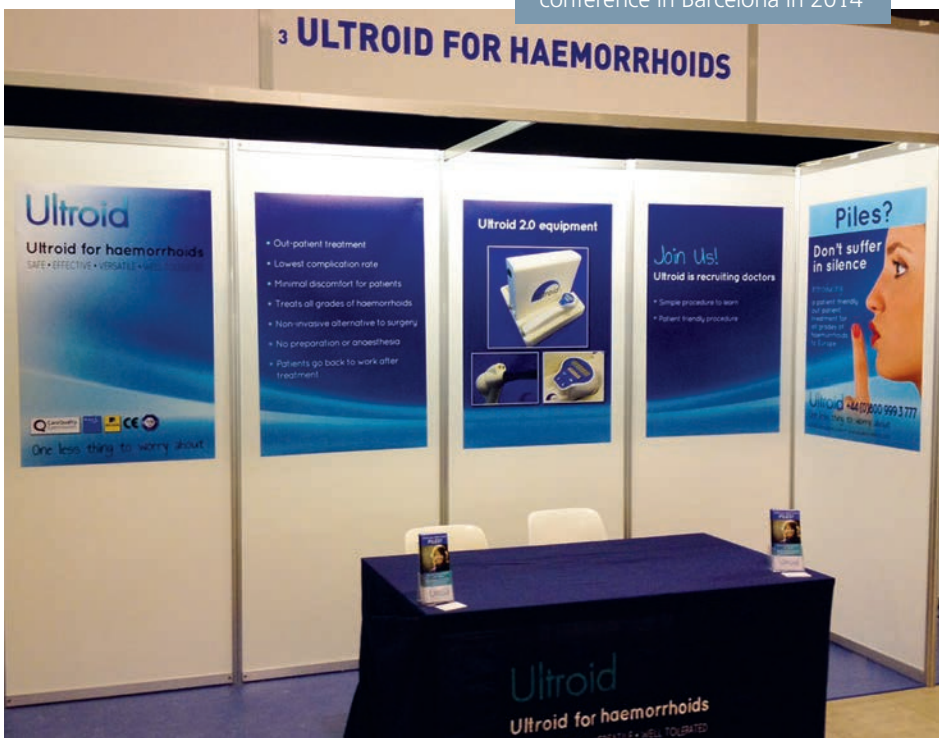
We maintain a centralised booking service via our own call centre. Quality control and clinical governance are especially important as we move forward and work with new doctors and clinics. As part of our duty of candour, training, audit, patient feedback and data collection continues, so that protocols can be reviewed and modified, and for any concerns or complications to be recorded and addressed where appropriate.

I am thrilled to be part of two great teams who are caring and passionate about skin problems and about Ultroid as a treatment for haemorrhoid disease – and all starting from the Canterbury Skin and Laser Clinic, a forward-looking innovative clinic in the heart of Kent.

ABOUT ULTROID UK LTD

- Established 2012
- First Ultroid clinic in the UK (opened in 2013)
- Ten clinics expected to be open by June 2015
- Care provided by trained doctors only
- Covered by Bupa, Aviva and WPA (others being agreed following recent NICE approval)
- NICE approval granted in June 2015
- More than 750 patient treatments carried out to date in the UK
- More than 120,000 treatments carried out worldwide

The Ultroid stand at the ESCP conference in Barcelona in 2014



Appledore Dental Clinic

British Dental Association Good Practice Award

Dr Teresa Day discussing treatment with a patient

ABOUT APPLEDORE DENTAL CLINIC

Founded in 1990 by Dr Teresa Day, this private practice offers general dentistry as well as implants, orthodontic and other cosmetic treatments. The clinic team prides itself in the services it offers to nervous patients, and over the years the clinic has achieved a reputation for excellence, winning a number of local and national awards.

In 2010, Dr Teresa was awarded Highly Commended for the Patients Smile category in The Smile Awards, and team members have been nominated in their job categories. Dr Teresa is an active member of the charity Dental Mavericks, a group that travels to North Africa annually to deliver pain-free dental care to disadvantaged children.

The founder of Appledore Dental Clinic, Dr Teresa Day, suffered traumatic dentistry as a child, and the clinic is a leading light in the treatment of traumatised patients. The clinic has a clear emphasis on providing patients with the education and skills to enable them to take ownership of their own dental health. There are two clinics, one in Bracknell and one in Milton Keynes.

Many patients come to Appledore who have been upset, scared and not listened to in the past. Using a combination of modern dental techniques and significant one-to-one time, the team excels in providing reassurance and gaining trust. Some patients are so scared they are unable to visit the clinic, so a Smile Advisor will offer to meet them first in a coffee shop or the car park just to chat and begin the, sometimes long, pathway to allaying their fears.

To assist in the delicate nature of treating nervous patients, the clinic is proud to have been one of the first in the country to have the Magic Wand, a pain-free way of administering local anaesthetic, and to use air abrasion, where aluminium oxide particles in compressed air are used instead of a drill to clean small cavities.

For very nervous patients Appledore provides sedation:

- Relative analgesia – mild sedation with nitrous oxide and oxygen – is extremely safe and can be used on small children as well as patients with health issues. It is applied through a small nose mask.
- Intravenous sedation – a visiting anaesthetist can provide this for patients who need more support.

» CASE STUDY

Appledore recently treated a 28-year-old man seeking a solution to his severe orthodontic problems. There was serious overcrowding and his upper teeth were very protruded. He had poor oral hygiene, presenting with extensive plaque and tartar, and he had not visited a dentist for over 2 years. Following an x-ray scan it was possible to see the start of some bone loss, and the front teeth were a little loose. It was clear the patient needed to take ownership of his dental health.

Two 1-hour hygiene appointments in quick succession and a programme of cleaning were recommended, together with stopping smoking. Three weeks later, with the hygiene appointments complete, the patient returned ready to start his orthodontic treatment with a heightened level of motivation to look after his oral health.

> "A well-qualified, knowledgeable team is happier, more motivated and better equipped to deliver high standards of care"

Appledore employs a 'whole-team' approach, whereby all team members have contact with patients and have input to their treatment, and promote the same preventive-care messages. Team members, particularly the hygienists and therapists, spend a great deal of their time supporting patients by helping them understand their dental problems and how they can prevent them. Good oral hygiene and regular dental maintenance can enable patients to keep their teeth for life, and make the difference between success and failure of more complex treatments.

Much of the team's work involves implants and orthodontics. However, no cosmetic or orthodontic work is undertaken unless the basics of good oral hygiene are in place and the supporting structures are sound. As a result, Appledore's success rate for implants is over 95% at 10 years, which is at the upper end of the industry standard.

At each dental examination patients are given a dental care report that indicates clearly what treatment is needed and the timescales, both short and longer term. The report covers:

- treatment that is required now – urgent
- treatment that will be needed within 6–12 months – not urgent, but recommended
- treatment that is likely to be needed over the next 5 years
- other treatment that the patient may wish to have – mostly cosmetic or feel-good dentistry such as whitening or orthodontics.

Education is taken to heart by the whole team in the belief that a well-qualified, knowledgeable team is happier, more motivated and better equipped to deliver high standards of care. The clinic supports its staff in training to the highest standards, offering in-house education on many aspects of dentistry and customer care

The Appledore binfield team

Dr Teresa with Dental Mavericks, treating a child in Morocco

» EARLY INTERCEPTIVE ORTHODONTIC TREATMENT

At Appledore we believe that almost all orthodontic treatment can be completed without taking any teeth out. Most orthodontic problems arise due to the lack of growth of the jaws and the pressure on the growing jaws from the tongue, cheeks and lips – where these muscles exert pressure incorrectly.

A child may have a tongue thrust, an incomplete swallow or be a mouth breather. These are all habits that can be corrected by early interceptive orthodontic treatment at Appledore. We start a child with the Myobrace appliance, which is worn mainly during the night to help retrain the muscles that are not working properly. By using the Myobrace the jaws can grow correctly, allowing the teeth to erupt into the correct position. We can start this treatment at any time from 4 years old.

as well as opportunities to achieve nationally recognised qualifications.

- Clinicians and dental nurses have ongoing training above the legal requirement for continued professional development.
- Smile advisors are either undertaking or have achieved BTEC or similar dental reception qualifications.

The clinic has achieved the required standards of both the Care Quality Commission and the British Dental Association's Good Practice Scheme, the UK's leading quality-assurance programme for dental practices. Compliance with these programmes, although time intensive, is leading to consistently higher standards of quality and safety in patient treatment and care.

All products used in treatment are backed by extensive research and quality-assurance guarantees, and our clinicians never compromise by using cheaper alternatives.

As a service provider Appledore strives to meet the access demands of its patients. Appointments are available not just between 9 am and 5 pm but also on some early mornings, late evenings and Saturdays, and even on Sundays by arrangement. Patients also benefit from an out-of-hours service, enabling direct contact for dental emergencies. This flexible appointment system also works well for team members who need to manage their work hours around family commitments.

Communication with patients is key, not just face to face in the clinic but also via media such as Facebook. Appointments can be booked online, by phone or e-mail, via the clinic website or through our Facebook page, with reminders sent out via text, e-mail or letter according to patient preference.

For nervous patients, Facebook has become a wonderful way to start a dialogue without patients having to leave the safety of their homes. Patients come to know the team through messages and discussions, and find reassurance in patient testimonials. Nervous patients are welcomed into the clinic on a weekly basis and supported in their first tentative steps to overcome their fears and to take control of their dental problems.

» MOUTH CANCER CHECKS

Appledore was one of the very first dental practices in the UK to purchase the VELscope, a potentially life-saving machine. Its blue light stimulates the natural fluorescence in the soft tissues, allowing dental professionals to see disease sometimes not visible to the naked eye. The VELscope is used in combination with traditional examination procedures to look for abnormalities that could possibly lead to oral cancer.

Surrey Physio

Physiotherapy plays an important part in helping people back to work

Tim Allardyce, Clinical Director and Owner of Surrey Physio

Almost 31 million days of work were lost last year due to back, neck and muscle problems, costing employers £5 billion, according to the Office for National Statistics. Musculoskeletal disorders are associated with high costs to employers such as absenteeism, lost productivity, disability and workers' compensation. Management of musculoskeletal injury is a key issue for every employer, from the implementation of relevant health and safety legislation, to managing related sickness absence and injury claims.

Private physiotherapy practices now play an important part in helping people back to work. Research shows that if more patients could get to a physiotherapist quicker, lost days would be limited and companies would save money. In one study from the Chartered Society of Physiotherapy, 80% of people who received physiotherapy for their musculoskeletal disorder were able to carry on working.

Surrey Physio is one such practice showing that providing high-quality physiotherapy quickly and efficiently can save local businesses thousands of pounds. Surrey Physio is one of the leading physiotherapy and sports rehabilitation clinics in South London. The company was originally established as Croydon Physio in 2005 but branched out in 2008 as Surrey Physio. Founded by Tim Allardyce, one of the UK's leading sports physiotherapists, the company very quickly gained a reputation for producing superb results, and Tim now leads a team of skilled physiotherapists, osteopaths and pilates instructors. The clinics cover London, Surrey and north-east Hampshire, and treat many common complaints such as spine and joint problems, recent or long-standing injuries, sprains, strains, nerve problems, sports injuries and postural and work-related

ABOUT SURREY PHYSIO

- Established in 2005
- 12 clinics in London, Surrey and North Hampshire
- Over 98% patient satisfaction
- Members of the Chartered Society of Physiotherapy
- Awarded NHS Any Qualified Provider contracts in Wandsworth and north-east Hampshire

> "providing high-quality physiotherapy quickly and efficiently can save local businesses thousands of pounds"

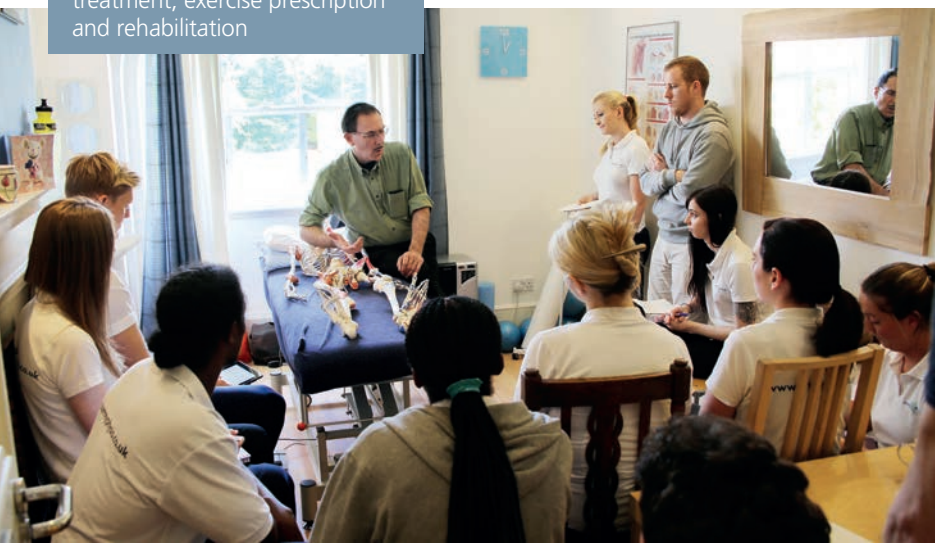
injuries. Providing patient satisfaction and producing the best clinical results is at the forefront of the company, as are life-long learning and enjoying the job.

Physiotherapy is a dynamic profession that uses a range of treatment techniques to restore movement and function to the body in cases of illness, injury and disability. Physios are the third-largest health profession after doctors and nurses. They work in the NHS, in private practice, for charities and in the workplace through occupational health schemes. At the clinic, patients receive detailed assessments and then agree goals and treatment plans with the physiotherapist.

'We have an incredibly diverse and interesting patient case load,' says Tim Allardyce, Clinical Director. 'Our patients are referred by local GPs, consultants, sports coaches or just simply by word-of-mouth recommendation. We provide an honest service by informing patients at all times of their progress, and doing our best to help them to achieve a full recovery as quickly and safely as possible.'

In 2011, the Department of Health published *Operational Guidance to the NHS: Extending Patient Choice of Provider*, which set out guidance on implementing the Any Qualified Provider (AQP) approach for musculoskeletal services for back and neck pain. In this approach, patients can choose where to have their treatment. This is in line with the government's objective to bring primary care out of the hospitals and into the community, but is also about raising quality by making the services more competitive. Surrey Physio was awarded the Wandsworth NHS Back and Neck pain AQP contract in 2012 and the North East Hampshire NHS AQP contract in 2013. These contracts equate to 3,100 patients treated and 13,000 appointments. The average waiting time for an appointment was 7 days, with every patient receiving individual care, and patient satisfaction was 98% overall. The practice works across a wide diversity of client groups, treating patients through the clinics, as well as within health centres, GP surgeries and sports clubs.

Keeping the team up to date with the latest advances in treatment, exercise prescription and rehabilitation



Surrey Physio professionally manages a physiotherapy and administration team, observing a clear clinical governance framework and guidance on professional standards produced by the Chartered Society of Physiotherapy and the Health Care Professions Council. Weekly in-house training and continuing professional development keep the team ahead of the game and up to date with the latest advances in treatment technique, exercise prescription and sports rehabilitation.

By continuing to meet the standards of proficiency, our therapists are able to ensure the quality of their practice and deliver a safe and effective service to the public. This has allowed growth and helped the company build strong relationships with and links to the community of healthcare professionals, sports coaches and athletes.

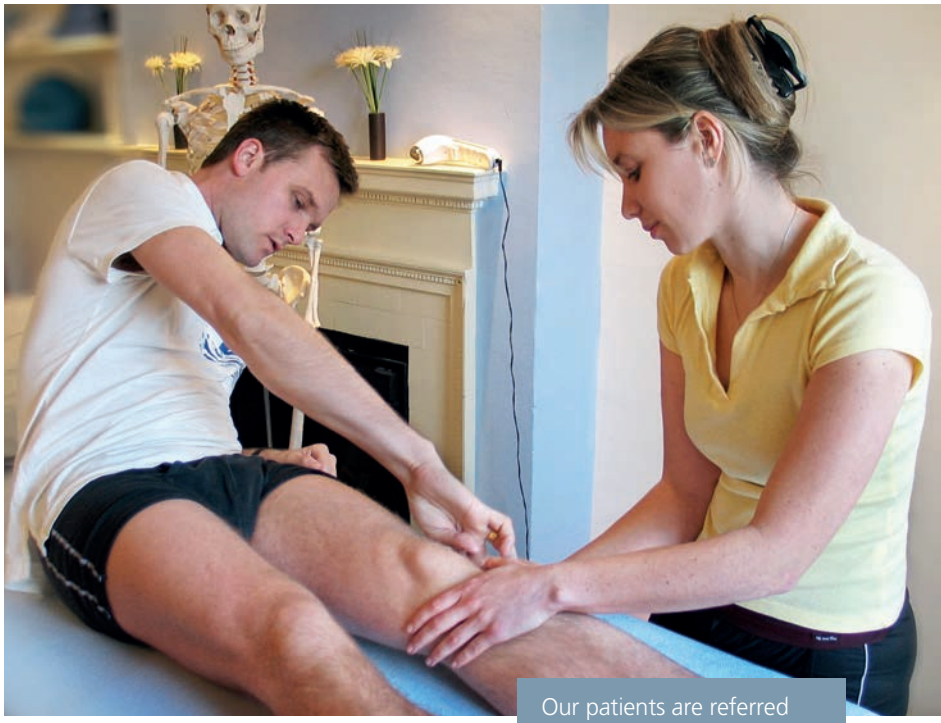
The Surrey Physio team has been heavily involved with international sports competitions. In 2010, Tim was a volunteer at the Winter Olympic Games in Vancouver, working directly with the Ghana Ski Team as the team physiotherapist. In 2012, three members of the team went to the London

Olympic Games, two as volunteer physiotherapists and one as the lead physiotherapist for men's goalball, a Paralympic sport. In addition, a number of our patients represented Team GB at the 2012 Olympics. In 2014, Tim was a lead physiotherapist at the Glasgow Commonwealth Games, and in 2015 was physiotherapist at the European Games in Baku, Azerbaijan. All sights are now set for Rio 2016.

> 'Working at an event like this was such an honour, and a great learning experience. Glasgow was buzzing, and the atmosphere was awesome. What a great time we had in August 2014, and thanks to Scotland and the town of Glasgow for hosting such a terrific event.'
>
> (Tim Allardyce, Director)

The company's success made it necessary to increase the number of therapists and services offered by opening more clinics. Surrey Physio now has clinics in 12 locations. Many clinics are located within GP practices, which allows GPs to refer patients directly for both NHS and private treatment. In addition, Surrey Physio is registered as a specialist with all the major health insurance companies.

Our strategy for the next 5 years is to continue to grow and deliver high-quality care in response to patient feedback and the requirements of commissioners. Funding from external sources or investors will be an important part of our strategy as we look to scale up our operation. We are looking to introduce more technology into our clinic to assist patient rehabilitation, such as software provided by Rehab My Patient. We will continue to train our staff to ensure high-quality, safe care and deliver the right support for every patient to ensure that they benefit from our treatment.



Our patients are referred by local GPs, consultants, sports coaches or just simply by word-of-mouth recommendation

» CASE STUDY

Mrs Hawthorne, a 34-year-old pharmacy assistant, suffered an episode of acute lower back pain when unloading a tumble dryer at home. She was referred to physiotherapy by her GP after a course of painkillers had not worked. Her GP faxed the referral form to us, and within 24 hours Mrs Hawthorne received a telephone call to book her appointment. She was offered her first appointment within 3 days of the referral being faxed, and saw us 5 days after her GP consultation.

During her treatment, it was quickly established that the cause of her pain was repetitive forward bending over a sales counter, which was creating muscle strain in her back and placing unnecessary load through her lower back. She had also become more sedentary, stopping exercise classes for fear that they might hurt her back.

Treatment consisted of specific joint mobilisation of the lumbar spine and thoracic spine to ensure good spinal mobility, and electrotherapy to reduce muscle spasm and inflammation. Specific soft tissue techniques were used to reduce tension in the lower back muscles. Mrs Hawthorne was given advice and exercises on posture, stretching and core stability.

After four sessions, Mrs Hawthorne made a full recovery and was able to return to her everyday activities pain-free. She planned to continue with the advice and exercises to prevent the injury recurring. Her physiotherapist estimated that 10 days off work had been saved as a result of the physiotherapy intervention. At 3 months after finishing the course of treatment Mrs Hawthorne had not had any recurrence of back pain.

The Cliffs Chiropractic Clinic

Exceptional patient care is our standard, constant and never-ending improvement is our strategy

Paramjit Nandhra BSc(Hons)Chiro PGCert DC MRCC, Melanie Cutting DC MRCC MNIMH and Arif Soomro DC MRCC FICPA CCPP

The Cliffs Chiropractic Clinic in Southend-on-Sea has one aim: to be outstanding. Established in 1994 by husband and wife Arif Soomro and Melanie Cutting, the ethos of the clinic is to set a high standard of chiropractic healthcare and to take every aspect of the clinic's service to an elite level. The clinic is a custom-designed, centre of excellence for the rapid management of the spine, muscles and joints and their effect on the nervous system, offering excellence in evidence-based, patient-centred care in a modern, friendly environment.

Our commitment is to exceed expectations every step of the way, from the patient's first point of contact with our front-of-house team to delivering diagnosis and treatment. Our goal is for patients to be in no doubt of our desire to provide the very best care and service available.

'I feel like a person not a statistic; it starts at reception and follows through.'
(Taken from our recent patient satisfaction survey)

The team

Our multidisciplinary team has at its heart a self-imposed standard of delivering the best treatment for each patient, putting the person, rather than their problem, at the core of our approach. Team members have been selected not only for their clinical excellence but also for their enthusiasm to learn, willingness to help, and their caring and friendly approach. The core value of excellence is adopted throughout the clinic and is showcased daily by our devoted front-of-house team.

ABOUT THE CLIFFS CHIROPRACTIC CLINIC

- Established in 1994 by husband and wife Arif Soomro and Melanie Cutting
- Multidisciplinary team of therapists
- Multi-award winning clinic delivering evidence-based, patient-centred care
- All our chiropractors are Members of the Royal College of Chiropractors
- Over 15,000 satisfied patients; our recent survey showed that 96% of people rated the clinic staff as 'very good' to 'excellent'

» OUR TEAM

- Arif Soomro: chiropractor, medical acupuncturist, certified chiropractic paediatric practitioner
- Melanie Cutting: chiropractor, medical acupuncturist, medical herbalist
- Paramjit Nandhra: chiropractor, medical acupuncturist
- Two sports rehabilitation therapists
- A remedial masseur
- A pilates instructor
- Two radiographers
- Four reception and clerical staff

Good health is a result of a well-balanced physical, chemical and emotional state. Patients who come to us are looking for an approach that gives them the ability to advance their health, focusing not only on pain relief but also on lifestyle changes, including exercise and nutritional guidance. It is our commitment to exceptional patient care that has determined our success.

Patient expectation

In 2012 the King's Fund identified that 'patient and public expectations are rising, patients and service users expect health services to be like other service industries and are willing to do more for themselves and interact with services via technology. They expect to be offered choice and variety and to experience services that are convenient, personalised and provided in modern buildings and healing environments.'

Communicating with the patient is the cornerstone of our practice; we educate and inform patients about the choices available to them in order that they can make the right healthcare decisions. Spending time with the patient is important. We assist patients in making decisions about their care, and offer them the opportunity to ask questions, building rapport and trust.

Patients seek the quickest path to pain relief and good health, which is why we are committed in providing emergency appointments, access to multidisciplinary care and multiple streams of patient education. We produce our own health-education leaflets, offer pilates exercise classes and regularly check our patients' progress using standard outcome measures and review appointments.

Our aim is not only pain relief and improved mobility but for our patients to understand their condition and be able to manage it themselves as effectively as possible in the long term. Freedom from pain and freedom of movement enable patients to enhance their life experiences and accomplish their aspirations.

Our website and monthly newsletter have been hugely successful in providing information and raising the profile and branding of The Cliffs Chiropractic Clinic. A PowerPoint presentation runs in our reception area to entertain and educate patients. Embracing social media has allowed for immediate patient interaction. Our Facebook page 'CliffsChiro' is very popular and our Twitter handle @CliffsChiro is gaining more followers by the day. WhatsApp is used as a handy method of communication between clinicians.

Key achievements

We are proud of our achievements, especially those in the area of patient satisfaction. Our recent patient survey showed that 96% of people rated the clinic staff as 'very good' to 'excellent'.

Arif Soomro, a Fellow of the International Chiropractic Paediatric Association and a Member of the Royal College of Chiropractic Paediatric Faculty, pioneered spinal screenings for children. He was asked to advise Ingatestone and Fryerning Junior School on ergonomic desks and

» TREATMENTS

The Cliffs Chiropractic Clinic offers a broad range of treatment options, including:

- chiropractic
- paediatric chiropractic
- craniopathy
- sacro-occipital technique
- medical acupuncture
- medical herbalism
- sports rehabilitation
- massage
- pilates
- nutritional support

Accurate diagnosis is the key to fast and effective pain relief

Computerised imaging allows our radiographers to produce high-quality x-ray images

chairs, incorporating part of the British Chiropractic Association's Straighten Up UK programme. The school was the first in Britain to instigate this facility, and the initiative resulted in Arif being asked to advise the National Healthy Schools Programme, a Department of Health project.

We are passionate about engaging with our local community and support Trinity FC, a local boy's football club, by sponsoring their kit. In addition, we have an automated external defibrillator that is available for all to use in the neighbourhood, an area that is characterised by a large elderly population and a host of holidaymakers.

Challenges

Chiropractic needs to become more highly regarded, more widely utilised and accessible to all, and this will be attained through achieving the highest quality standards based on clinical guidelines and expert judgement.

The profession needs to alter some misconceptions about chiropractic care and encourage more interprofessional understanding. The clinic has, in the past, initiated a relationship with a local consultant where medical students spent a day at the clinic to observe our scope of practice. We are now continuing this initiative with medical students from Cambridge University.

Research producing a strong evidence base will be core to the future success of the profession. Numerous international studies have shown that chiropractic treatment is both safe and effective, and chiropractic is included in the NICE Guidelines 2009 and Royal College of General Practitioners' Clinical Guidelines for the Management of Acute Low Back Pain (1996, 1999, 2001).

Although a small profession with limited funds, chiropractic in the UK continues to develop high-quality research at academic institutions. For example, the Anglo- European College of Chiropractic (AECC) in Bournemouth has recently installed the UK's third open upright magnetic resonance imaging (MRI) scanner. This is the newest generation in magnetic imaging equipment and, together with objective spinal motion imaging assessment (OSMIA), a form of digital fluoroscopy, provides the most complete imaging package for spine mechanical diagnosis available anywhere.

The Cliffs Chiropractic Clinic supports research through donations received for child screenings, and a percentage of our profits from sales are given to the AECC and British Chiropractic Association research funds.

We feel that our holistic approach not only allows us to provide the highest quality of care but, alongside our dedication to improving standards, our elite service and our support of research within the field, also serves as an example of how effectively every chiropractor can contribute to the progression of the profession.

» ACHIEVEMENTS

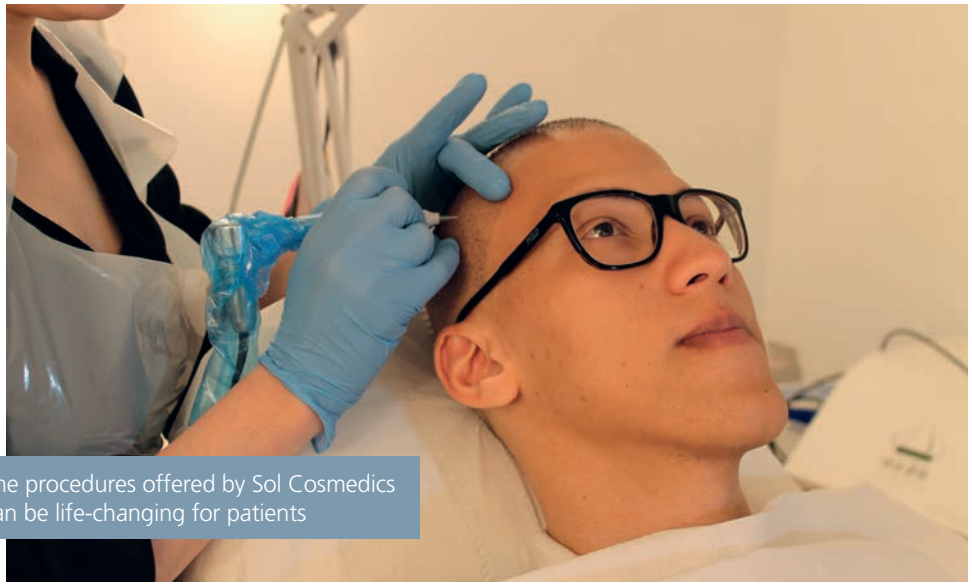
- Patient Partnership Quality Mark (PPQM) 2012, 2015
- Clinical Management Quality Mark (CMQM) 2013

The above awards recognise excellence in meeting patient expectations and operating within a structured and managed clinical environment, including the use of outcome measures, audit, risk management and patient safety

- Care Quality Commission (CQC) registered
- The first chiropractic clinic in the country to install a computerised x-ray system (2003)
- 2014 Customer Service Award from the global clinic comparison site WhatClinic.com.

> "Freedom from pain and freedom of movement enable patients to enhance their life experiences and accomplish their aspirations"

Sol Cosmedics



The procedures offered by Sol Cosmedics can be life-changing for patients

Hina Solanki, founder and leader of Sol Cosmedics

Led by renowned permanent make-up artist Hina Solanki, Sol Cosmedics is an internationally regarded provider of micro-pigmentation (also known as permanent make-up, semi-permanent make-up and cosmetic tattooing). The specialist services that the company provides, including cosmetic and paramedical scar camouflage, have transformed the lives of thousands of patients.

Following a health scare of her own and in need of micro-pigmentation, Ms Solanki developed expertise in medical scar camouflage using permanent make-up. She is passionate about helping others rediscover their self-confidence after suffering illness or injury. Medical patients of all ethnicities and from across the globe seek the expertise of Sol Cosmedics for scar-camouflage procedures, and the number of patients coming from abroad is increasing every year. Hina Solanki's work has made a lasting impression on the permanent-cosmetic industry, and she frequently works alongside London's top cosmetic surgeons.

> 'People may well have complex issues but sometimes it makes a lot of sense to deal with the most obvious problems, and that could promote healing from within.' (Hina Solanki)

Cosmetic tattooing or permanent make-up is used to mimic the look of ordinary make-up, and may be used for cosmetic enhancement or scar camouflage. Although permanent make-up has only become popular in the last 10–15 years, there is evidence from figurines that women had tattoos on their bodies and limbs as long ago as *c.* 4000–3500 BC. However, despite the fact that there are hundreds of micro-pigmentation artists around the world carrying out hundreds of successful

ABOUT SOL COSMEDICS

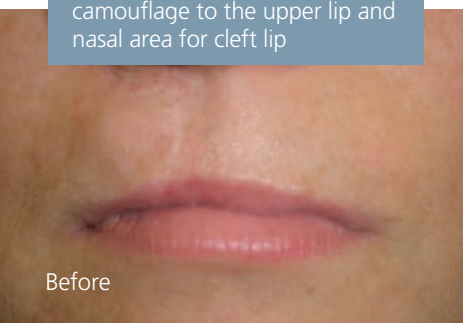
- Founded and led by internationally renowned permanent make-up artist Hina Solanki in 2006
- Provides cosmetic and paramedical procedures
- Clinics in Finchley Central, North London, and Harley Street, Central London
- A UK leader in micro-pigmentation procedures
- Internationally recognised specialist in micro-pigmentation

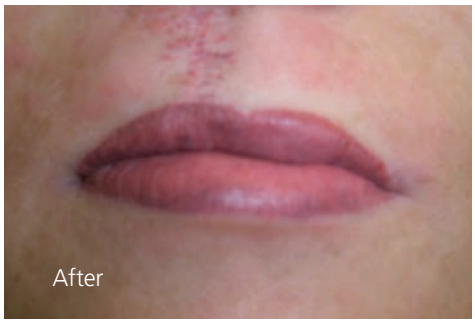
Applying micro-pigmentation for eyebrow enhancement

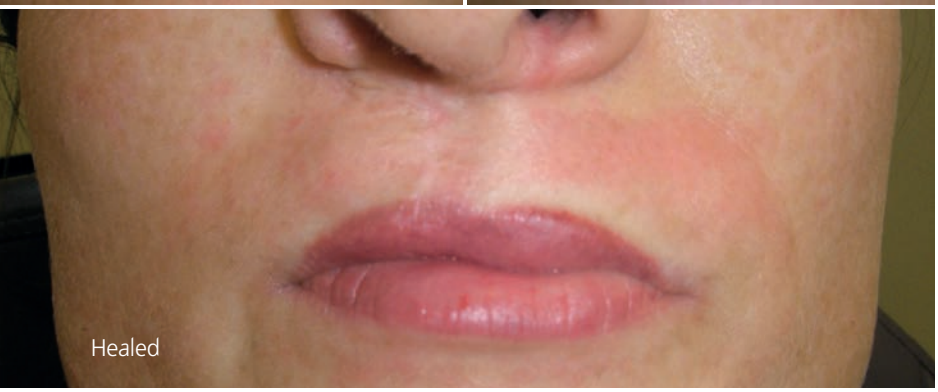
procedures every day, many people who may benefit from the procedure do not understand what permanent make-up is and/or are unaware of the full potential of its benefits.

Permanent make-up is a cosmetic technique that implants pigment in the skin by means of a single-use fine needle. It is a form of tattooing, but the pigment is only implanted into the upper dermal layer. A conventional body-art tattoo is implanted deeper into the dermal layer, making it last longer or even a lifetime. A permanent make-up procedure generally lasts for 1–5 years, and can be maintained by a colour boost every 12–18 months.

Lip-enhancement and scar camouflage to the upper lip and nasal area for cleft lip







The UK is fortunate to have some of the best permanent make-up artists, but Sol Cosmedics is one of the only clinics in London that deals solely with micro-pigmentation. Because our work is so focused, our practitioners have a full understanding of current clinical procedures and their specialist expertise can be applied to achieve exceptional patient care and effective results. As specialists in the field, Sol Cosmedics also takes on patients with more complex paramedical scar camouflage from other permanent make-up technicians.

In addition, the team at Sol Cosmedics ensures that every client feels completely comfortable – nobody should ever feel embarrassed or be made to feel uneasy about the procedure they wish to have. This aspect is paramount in customer-service training within our clinics in Finchley Central in North London and Harley Street in Central London.

The ethos of Sol Cosmedics is to deliver excellent, focused, individualised, empathetic patient care.

Permanent make-up for eyebrows, eyes and lip enhancement

Eyebrow hairs may be sparse due to alopecia, chemotherapy or just heredity, fallen eyelashes can make the eyes look dark and tired, and lips can lack definition and colour. Permanent make-up can provide significant cosmetic enhancements in all these situations. Notably, the appearance can be significantly improved in cases of cleft lip

through a lip-enhancement procedure combined with scar camouflage to the upper lip and nasal area.

Medical scar camouflage

Scar-camouflage tattooing, also known as paramedical micro-pigmentation, can be carried out to ameliorate alopecia (hair loss), vitiligo (white patches on the skin), the visual effects of chemotherapy and breast reconstruction, surgical and other scars, and burns, anywhere on the face or body.

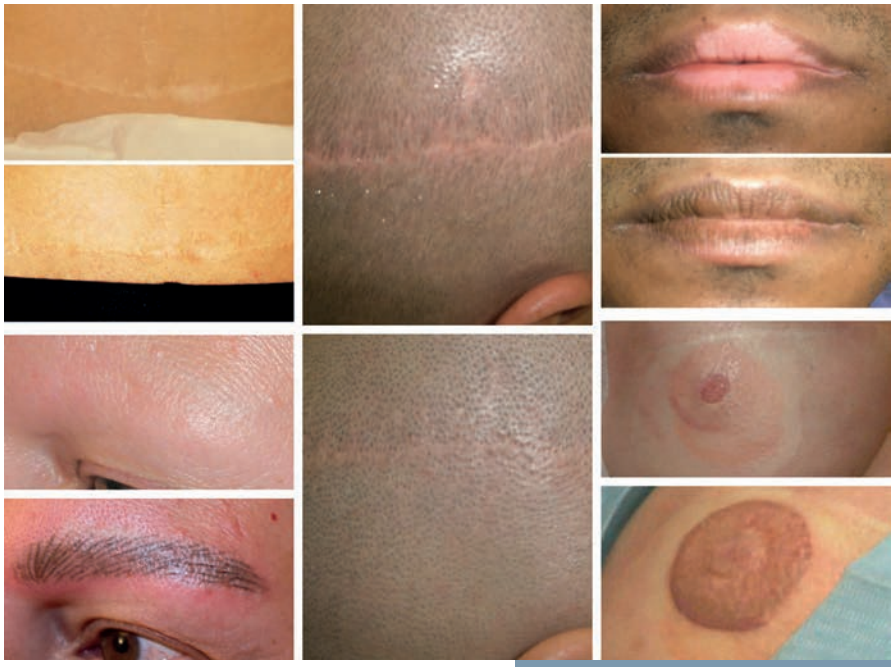
Several different colours of pigment are blended to match the skin tone of the patient, giving the work a natural-looking finish. The aim is to make the scar less noticeable so that the eye is not drawn to it straight away.

Scar camouflage has the important benefit of lifting self-esteem, and can be a real confidence booster. Living with scars can affect individuals in their work and relationships, may prevent them from taking part in sporting activities and feeling comfortable wearing certain items of clothing. For many people, scar camouflage has been a life-changing procedure.

The future

Procedure techniques are, rightly, changing, with the aim of providing better results, from the first consultation to the provision of aftercare. However, we would like to see:

- more private health insurers cover micro-pigmentation procedures, which can be life changing for people who have suffered scalp, eyebrow and eyelash hair loss after chemotherapy
- more support and information for cancer patients, who may need tattooing after breast reconstruction surgery
- micro-pigmentation training schools providing some type of update for technicians on new practices within health and hygiene
- more outsourcing of scar-camouflage work by the NHS to reputable specialist clinics like Sol Cosmedics, especially for patients who are suffering from alopecia and vitiligo.



Scar-camouflage tattooing has the important benefit of lifting self-esteem

In addition, there needs to be greater awareness of micro-pigmentation and its benefits. At Sol Cosmedics we are passionate about spreading the word – no one should need to suffer in silence because they do not know about the availability of these potentially life-changing procedures.

What we have learnt

Sol Cosmedics has concentrated only on cosmetic micro-pigmentation and paramedical scar camouflage tattooing. As a consequence of its highly focused specialisation, it has been able to create and maintain a service that is second to none. At Sol Cosmedics we have learnt that there is a place in the UK private healthcare sector for small, independent specialist clinics that have the ethos of Sol Cosmedics – delivering excellent, focused, individualised, empathetic patient care.

> “No one should need to suffer in silence because they do not know about the availability of these potentially life-changing procedures”

Rodericks

Rodericks' dental clinic at Bilborough

Rodericks offers NHS and private care and services

ABOUT RODERICKS

- 55 sites with more than 400 dental professionals across England and Wales
- NHS and private dentistry provided to over half a million patients every year
- Approach is 'always putting our patients' best interests first'
- Board of Directors consists of dentists with many years' experience in delivering excellent dental care and training foundation dentists
- 16th in the Zolfo Cooper Growth Company Award for healthcare companies showing the greatest growth in performance over 3 years
- Included in the inaugural London Stock Exchange Group's '1000 Companies to Inspire Britain', a list of the most inspiring small and medium-sized enterprises in the UK

The ultimate goal of Rodericks Ltd is to be the best dental company in the sector. We constantly strive to be the first-choice dental provider for patients, dentists and employees across the UK. Our key values ensure we remain focused on the standard of care delivered to our patients – we always act in their best interests, ensure clear and concise communication, and deliver first-class clinical treatment. Our values are also underpinned by complete dedication to our staff; we encourage all staff members to meet and even exceed personal career aspirations, and provide every opportunity to enable them to do so.

Strict and ongoing quality-assurance protocols are implemented so that we can monitor how we achieve these targets and ensure that we meet the high standards we set for ourselves. We embrace patient feedback so that we can continually elevate the quality of care and treatment we offer and further tailor our services to meet the demands and expectations of our patients. We are, and always have been, keen to refer to those we care for as 'patients' rather than 'customers'. The latter implies a retail element, suggesting that sales are important, whereas with 'patients' the focus is brought back to health and wellbeing, which aligns with our core values as a dental care provider.

Increasing patient access

Part of Rodericks' mission as a company is to increase patient access to high-quality dental treatment throughout the country. All our practices offer both NHS and private treatment and services, ensuring a choice of services tailored to suit a wide variety of individual patient needs. We are particularly keen to improve access to dental care

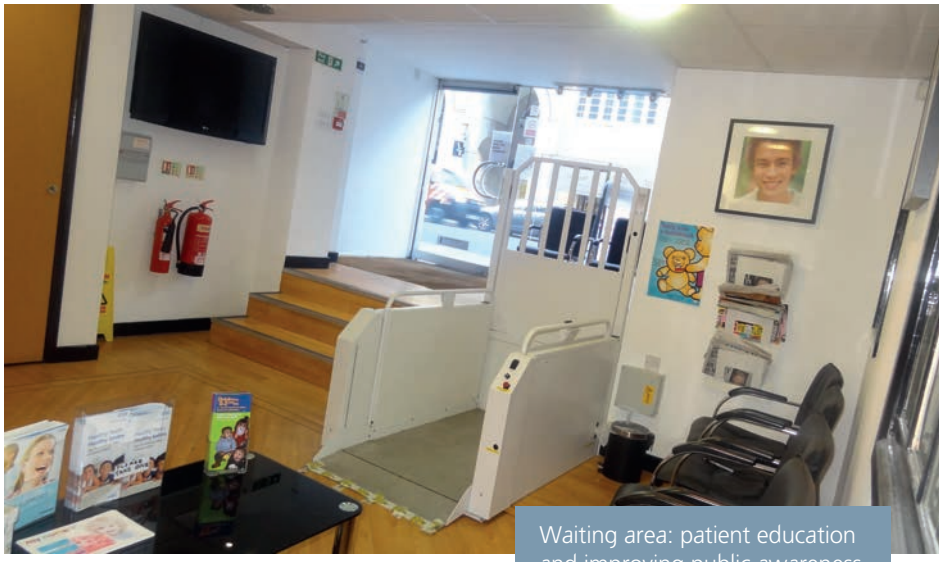
for communities that need it most. We have successfully bid for several tenders in deprived areas of the UK in an attempt to connect with those groups that are most difficult to reach. The most recent Adult Dental Health Survey (2009) found a clear link between socio-economic status and oral health, and over the past six years we have strived to establish practices in poorer areas to deliver access to the dental care residents need.

Currently we have 55 practices located throughout central and southern England, of which 34 are in deprived areas. More than a third of these were classed in the 2014 Health Profiles published by Public Health England as regions experiencing high deprivation. The same Health Profiles identified that some of the highest rates of deprivation are in and around Nottinghamshire and Derbyshire, where Rodericks already runs several mixed NHS and private dental practices. Through locating services in these areas we hope to provide the access to dental care that people living in these areas so greatly need.

In all our practices we focus on providing patient education and improving public awareness of the importance of oral health and related issues. We believe this to be truly vital in communities where lower standards of health prevail.

Looking after professionals

In order to deliver exceptional standards of clinical dentistry, it is essential that all members of Rodericks' professional teams have sufficient skills and experience. We encourage all staff to undergo training throughout their time with us, and provide various in-house educational opportunities and facilitate access to external training wherever possible. Staff can talk to management at any point should they consider advanced training, and our network of leading practitioners provides an ideal platform for sharing experiences and advice.



Waiting area: patient education and improving public awareness of the importance of oral health is vital

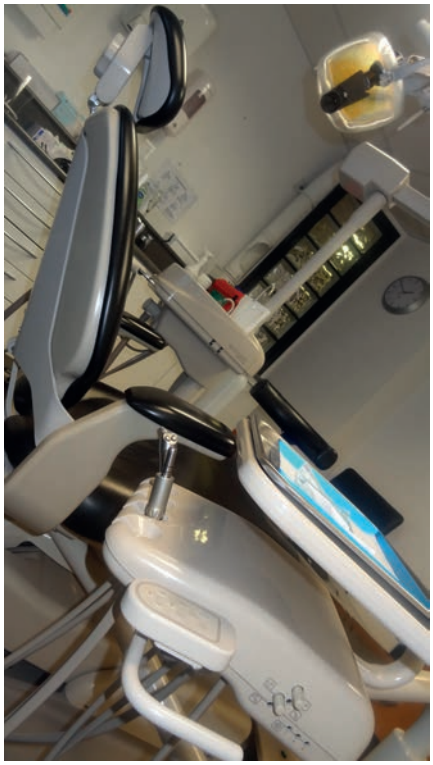
In addition, all our staff undergo training in the areas of patient care and communication, so that they have the skills and confidence to deliver the outstanding patient service expected of a Rodericks practice. Not only does this contribute to ensuring that all our patients receive the care and attention they need, it also helps create a more approachable and friendly atmosphere within practices. By enhancing the services we provide as a company, we are committed to driving standards up throughout the dental profession, in turn improving the quality of care available to the public.

Looking to the future

Rodericks is exploring many avenues for the future. These include broadening the variety of services currently available within our practices, to give patients more choice and better meet their individual needs. We hope to establish new oral-health centres within our network, so that patients may be referred for any specialist treatment they require and receive therapies from a provider they can trust to ensure their safety and quality of their treatment.

We are examining the Public Services (Social Value) Act with a view to adopting more holistic protocols and processes to secure wider social, economic and environmental benefits.

> "we have strived to establish practices in poorer areas to deliver access to the dental care residents need"



Rodericks aims to lead the way in increasing public access to quality dental care

Leadership by example is the strongest method of engaging with others in our sector, and we aspire to become one of the front-runners in dentistry to raise awareness and communicate the advantages of the Social Value Act to other providers.

Inspiring improvement

Through our current mission and future aspirations, we at Rodericks hope to remain a driving force for industry standards in dentistry. We aim to lead the way for the profession, increasing public access to quality dental care and raising the benchmark for clinical services throughout the UK. As dental professionals, we have the power and the opportunity to improve the quality of life of thousands of people, and we want to make the very most of this. The foundations are already there for us to build on, and we look forward to what the future may bring for the health and wellbeing of the UK.

» ABOUT THE AUTHOR

Shalin Mehra is one of the founders and Managing Director of Rodericks Ltd. With more than 25 years' experience working as a general dental practitioner, he has been an advocate for continued postgraduate education for some time. Closely involved with the training and development of future dentists, Shalin has worked as a Regional Advisor for Vocational Training in the Oxford area and Associate Director of the Oxford Postgraduate Dental Deanery. He is currently the Associate Postgraduate Dental Dean (Foundation Training) and Dental Faculty Development Advisor for Health Education England Thames Valley and Wessex.

Crowthorne Family Chiropractic Centre

Chiropractic is an evidence-based natural healthcare practice

Dr Michael Pim BS DC

The UK urgently needs to slow down the ever-increasing rate of healthcare spending on the NHS while still delivering quality healthcare. The chiropractic profession can help save the NHS significant amounts of time and money by reducing GP and consultant visits and investigatory procedures and medication, and at the same time improve patient outcomes.

How chiropractic can save the government money

Low back pain is one of the most common causes of disability among people of working age, and its impact on industry is enormous. It is estimated that four out of five adults (80%) will experience back pain at some point in their lives and that 10% of sufferers have visited a practitioner outside of medicine. The Chartered Institute of Personal Development reported that absenteeism costs companies £609 per employee per year, and back pain contributes 46–56% to the total cost of absenteeism. Musculoskeletal injuries, back pain and stress appear in the top five most common causes of short- and long-term absence and are key contributors to cost.

» Around 30 million adults in the UK will experience back pain this year.

» Around 10 million of them will experience pain and disability lasting more than 12 months, and 6 million of them will be off work for more than 3 months as a result.

» Back pain represents half of all chronic pain and costs the NHS £1.3 million every day.

When utilised as primary healthcare, chiropractic can help to:

» reduce hospital admissions

ABOUT CROWTHORNE FAMILY CHIROPRACTIC CENTRE

» Owned by Dr Michael Pim

» Located in Crowthorne, Berkshire

» In addition to chiropractic care, the centre offers many natural health therapies from nutrition to lifestyle coaching

» Dr Michael Pim is a second-generation chiropractor and comes from a family of four chiropractors, all of whom studied at Palmer College of Chiropractic, USA

» The centre has expanded to set up other branch practices at other places in the UK

» WHAT IS CHIROPRACTIC?

Chiropractic is a profession that specialises in studying and treating the function of the nervous system and the body. Chiropractors do not promote the use of drugs or surgery; they focus on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health.

Chiropractic is a major contributor to natural health in the UK and is regulated by the General Chiropractic Council.

- reduce outpatient procedures
- reduce days spent in hospitals
- reduce pharmaceutical costs.

The results of a 7-year clinical and cost utilisation study in Illinois, USA, showed that the use of chiropractic:

- reduced hospital admissions by 60.2%
- reduced hospital days by 59%
- reduced outpatient surgeries and procedures by 62%
- reduced pharmaceutical costs by 85%.

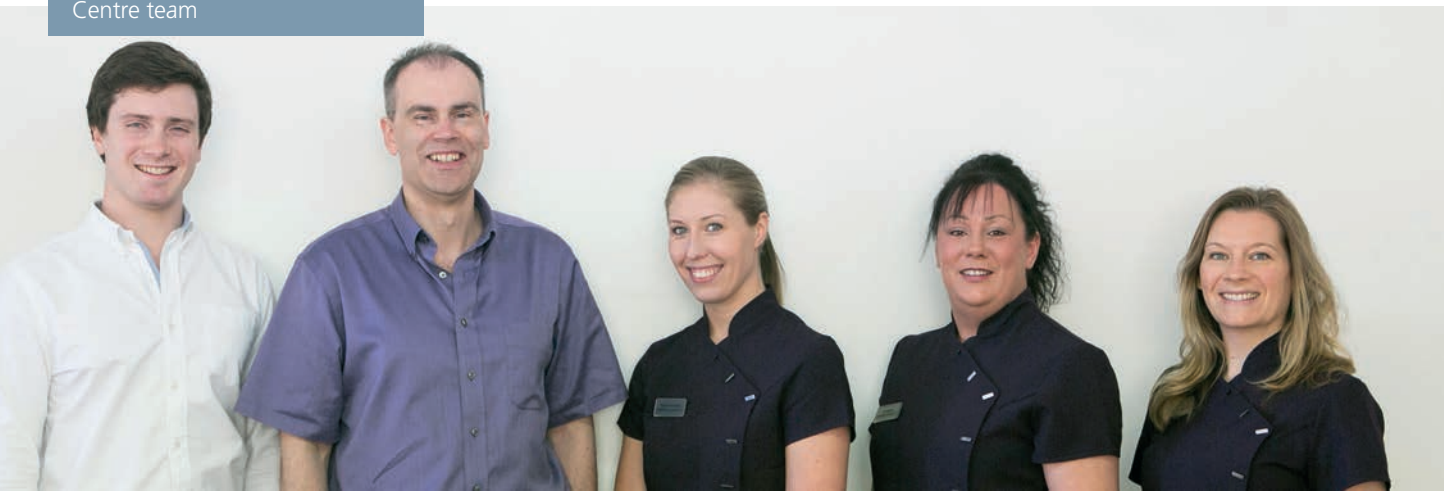
The inclusion of evidence-based healthcare approaches such as chiropractic care within health plans represents a significant advancement in cost and clinical effectiveness. In a study of 402 patients (in the lower back pain programme at Jordan Hospital, Plymouth, Massachusetts, USA) treated exclusively by chiropractors, successful clinical outcomes were achieved in an average of 5.2 visits at the low cost of $302 per case, and the patient satisfaction rate was above 95%. In addition, self-reported pain and disability scores were reduced by 70% over the course of a few weeks. Studies such as this one show the enormous benefit in terms of clinical outcomes and satisfaction rates that can be achieved when all healthcare professions work together as a team in a patient-centred approach, each doing what that trained health professional does best.

Utilisation of chiropractic and the NHS

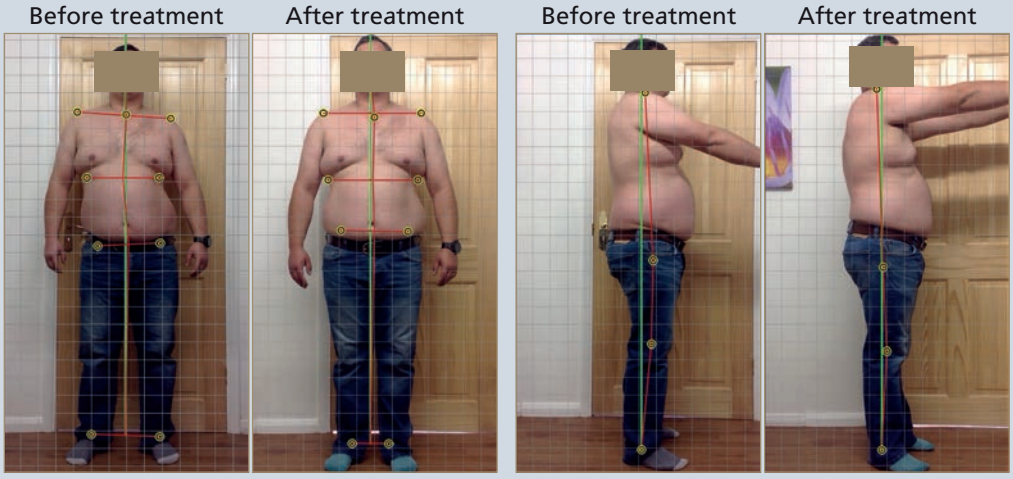
The best model for accessing chiropractic service from the NHS is one of independent assessment and self-referral, much like that which currently exists between a patient and their GP. In this model a patient can either self-refer for assessment by their chiropractor, or their GP can refer them for care. This would result in quicker resolution of the problem and better clinical outcomes for the patient, and reduced cost of care for the NHS.

By acting in partnership with the NHS as a distinct profession, and taking an approach that considers the whole

Crowthorne Family Chiropractic Centre team



» CASE STUDY



Peter first consulted Crowthorne Family Chiropractic Centre with a long history of back and spinal problems. After receiving chiropractic care over an 11-week period he has made significant improvements in many ways, from symptom reduction to increased strength, energy and wellbeing. On one measure alone, posture, you can see graphically the difference from when he first started to his last scan. This is a typical expected change that many chiropractic patients experience.

Posture-induced back problems are rising due to smartphone and tablet usage, especially in the younger population, and it is an area that chiropractic can help tremendously in so may ways, from less neck and shoulder tension and increased flexibility to a healthier spine and body.

patient and his or her circumstances (a bio-psychosocial approach), chiropractors can work in cooperation with the NHS for the benefit of the patient.

When all NHS professions are free of the obligation to find solutions only within the NHS and instead are able to inform and recommend to patients what is best for them clinically and let the patient decide, there will be greater choice for the consumer and better clinical outcomes. This, in turn, will give the NHS more resources and the ability to do what it does best. To facilitate this cooperation and interprofessional relationship, information and presentations need to be provided to NHS front-line professionals and students at medical universities to explain what chiropractic exactly is and can provide.

The common perception of chiropractic is often that it is limited to the treatment of back or neck pain. However, there is so much more that chiropractors do and can help patients with. As primary healthcare providers, chiropractors are well placed to assess patients as a first port of call, place them on the appropriate care pathway and maintain an overview of the full clinical process. It is commonplace to refer patients to other healthcare professionals when necessary to enhance the overall outcomes. The best model of care is one that is patient centred and where the individual choices of the patient are paramount.

By encouraging cooperation between the NHS and the chiropractic profession, government can truly reduce costs and dramatically improve the healthcare experience for patients. Put simply, chiropractic care is hugely successful and provides great value.

> 'The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and prevention of disease.'
>
> (Thomas Edison)

> "As primary healthcare providers, chiropractors are well placed to assess patients as a first port of call"

This article was written by Dr Michael Pim BS, DC, Doctor of Chiropractic, in conjunction with the United Chiropractic Association.

The Optimum Health Clinic Foundation

David Butcher, Chair of The Optimum Health Clinic Foundation

Meeting with ME/CFS patients

The Optimum Health Clinic (OHC) is an innovative, award-winning clinic that specialises in the treatment of myalgic encephalomyelitis and chronic fatigue syndrome (ME/CFS), a debilitating illness characterised by unending fatigue. The OHC was set up in 2004 by Alex Howard, who suffered from ME/CFS for 7 years and fully recovered. The OHC is based in London and has practitioners operating nationwide. The OHC is owned by The Optimum Health Clinic Foundation.

ABOUT THE OPTIMUM HEALTH CLINIC FOUNDATION

- Established in 2004 by Alex Howard, who had fully recovered from ME/CFS
- Owned by The Optimum Health Clinic Foundation
- Based in North London, with practitioners operating across the UK
- Specialises in the treatment of ME/CFS
- Treated more than 5,000 ME/CFS patients in the past 11 years
- Winner of the award for outstanding practice 2009 (*Complementary and Alternative Medicine Magazine*)

The World Health Organization recognises ME/CFS as a real physical illness. Having treated more than 5,000 ME/CFS sufferers over the last 11 years, we at the OHC believe that ME/CFS involves a process in which multiple systems, both physical and psychological, interact together in a dysfunctional way, resulting in the various symptoms experienced.

ME/CFS can shatter peoples' lives. As well as unending fatigue, sufferers often experience sleep difficulties, neurological disturbances, and excruciating muscle and joint pain. They are often bedridden for months, sometimes years, and are no longer able to work.

It is estimated that ME/CFS affects around 250,000 people in the UK each year, but recent studies have shown that only 8,000 patients are assessed and treated in specialist NHS facilities each year. Without treatment, less than 5% of patients will recover. In comparison, other chronic illnesses such as multiple sclerosis (100,000 patients in the UK) and Parkinson's disease (130,000 patients) are much more widely understood, supported and publicised. ME/CFS affects men and women, the young and old, and is one of the most misunderstood, poorly supported and underdiagnosed conditions of our generation.

The need for an innovative approach to treating ME/CFS

GP awareness of ME/CFS is generally very low, and yet each practice could be seeing 30–40 sufferers each year. Medical guidelines dictate that the diagnosis can only be confirmed after 6 months of symptoms, and the condition is often misidentified as depression, and medicated accordingly. This can help elevate the mood and psychological outlook of patients but will not reduce the fatigue and other symptoms. Even if patients are correctly diagnosed, the lack of support and understanding available makes the ME/CFS experience overwhelming, deeply frustrating and, at times, desperate.

The National Institute for Health and Care Excellence (NICE) 2010 guidelines recommend treating ME/CFS using a combination of cognitive behavioural and graded exercise therapy. However, large studies published in the literature have shown that this approach is only moderately effective in most patients. Patients have the illness for, on average, more than 6 years, but the NICE guidelines are based on less than one treatment session a year in NHS facilities. There is a clear unmet need for an innovative, effective and safe approach to the treatment of ME/CFS patients.

How the OHC helps

The OHC takes a unique integrative medicine approach. The Consortium of Academic Health Centers for Integrative Medicine describes integrative medicine as: 'the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing'.

ME/CFS is so complex that there are almost as many versions of the condition as there are individual sufferers. The OHC puts the patient at the centre of the treatment process by:

- recognising the physical and psychological complexity of ME/CFS
- looking at the biochemistry of each patient holistically
- applying a unique combination of nutritional therapy, functional medicine, conventional biomedicine and psychology.

The OHC's approach is unique because it is based on personal experience of ME/CFS. Eleven of the OHC staff, including seven of the eight psychology practitioners, have suffered from ME/CFS and fully recovered from it. Even the trustees have personal experience of the illness. The OHC is a truly patient-led organisation.

This personal experience means that the staff at OHC have the knowledge, confidence and belief that full recovery is possible, and they are able to impart that belief to their patients. This represents a fundamentally different starting point from that of conventional treatments, and no other private clinic offers an integrative medicine approach backed by a wealth of personal experience and understanding of ME/CFS.

The OHC is a community

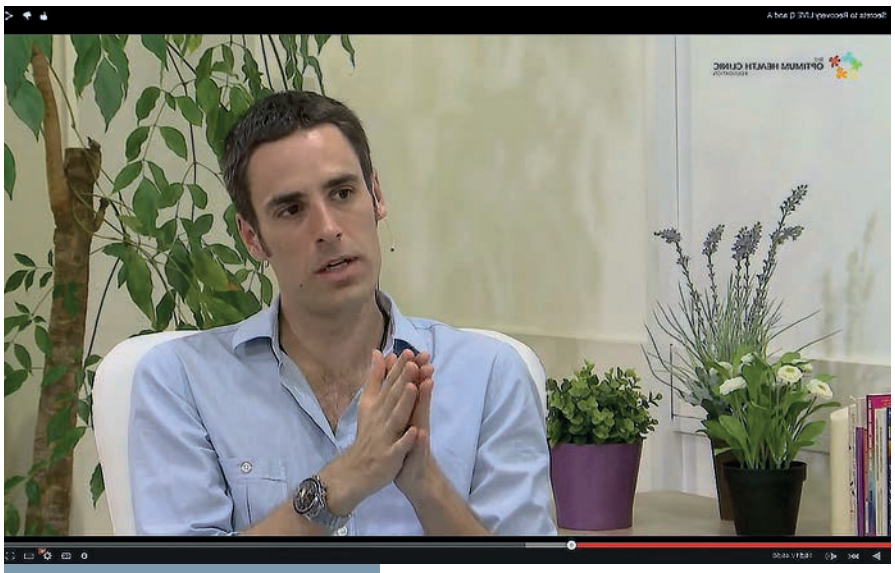
It is not just the OHC's integrative medicine approach that helps patients.

» DAVID BUTCHER'S PERSONAL ME/CFS JOURNEY

I was a CEO in the financial services sector. In 2005 I lost my job, in 2006 I lost my father to Parkinson's disease and a few weeks later I lost my wife to cancer. Then I succumbed to multiple infections. The combination of the cumulative stress of my job, emotional trauma and a series of infections was the perfect storm for ME/CFS. I spent 6 weeks in bed unable to move, and suffered from this horrible illness for 3 years. It was only because of the OHC treatments that I fully recovered.

Fortunately, I was one of the few lucky ones able to afford private treatment. I am so passionate about helping ME/CFS sufferers that I decided to become Chair of the OHC's charity, The Optimum Health Clinic Foundation, so I can help to make the OHC's mission of making integrative medicine available to all ME/CFS sufferers a reality.

Left to right: David Butcher (Chair), Ian Hatton (Trustee), Alex Howard (CEO) and Tim Bichara (Trustee)



The OHC's network of websites provides a huge amount of information and support

> "There is a clear unmet need for an innovative, effective and safe approach to the treatment of ME/CFS patients"

The organisation offers ongoing support in the form of:

- a network of websites that provide a huge amount of information and support and together receive 300,000 unique visits a year
- over 100 hours of audio and video
- a huge archive of inspirational recovery stories from OHC patients
- a social network where patients can find support from others who have experienced or are living with ME/CFS
- a monthly live internet TV broadcast of interviews with patients who have recovered from the illness
- a monthly newsletter, which is sent to over 10,000 people.

In 2009 the OHC was recognised for this work by *CAM* magazine, receiving its award for Outstanding Practice. In addition, in a recent survey 93% of patients said that they had benefited from working with the OHC.

The OHC's mission

The OHC's mission is to make integrative medicine available to all ME/CFS sufferers. To achieve this, we at the OHC believe that our long-term strategy of funding research to demonstrate to the NHS the effectiveness of our treatments is the only real choice.

In a survey done by the OHC in 2014, 90% of respondents said that they did not become a patient of the clinic because of the costs of treatment. This is why we are passionate about making treatment freely available to all ME/CFS sufferers.

Our controlled clinical trial

To achieve our mission of enabling more ME/CFS patients to receive the OHC methods of treatment, it is necessary to create an evidence base that the NHS will accept.

In 2012 the OHC published a preliminary study in the *BMJ Open*. The study showed that ME/CFS patients who were treated using the integrative medicine approach had a significant improvement in some symptoms after only 3 months of treatment. These results provided the OHC with a platform and a rationale for undertaking a full clinical trial.

A randomised controlled clinical trial will be conducted in NHS facilities. Some key parameters will be measured that will determine if patients improve on the OHC treatments. It is hoped that the trial will demonstrate conclusively the sustainable effect of the OHC's integrative medicine approach and provide evidence that it is effective and safe. Patients will be recruited from GPs who have shown an interest in alternative approaches to the treatment of ME/CFS and from the 49 specialist NHS clinics that treat ME/CFS patients.

» THE OHC'S BROADER OBJECTIVES

The OHC does not just want to persuade the NHS to offer its integrative medicine approach to all ME/CFS sufferers. It wants to:

- work with other ME/CFS charities to secure greater funding for research into the physiological causes of the condition
- raise awareness of integrative medicine within the ME/CFS community and the broader medical community
- continually improve its own integrative medicine approach and standards of patient care
- undertake research into the application of integrative medicine treatments to other complex, chronic illnesses.

Bridge Mental Health

Medium support services – Adeyo is supported by Bridge's dedicated, skilled staff

Raymond Sheehy, CEO of Bridge Mental Health

There's no short cut to dealing with mental health problems. I wonder what progress would be made if we put mental health on a par with physical health when we are supporting people on the difficult road to recovery. If health and social care services really started working together, then recovery for many people with mental health problems would start to become a reality. I believe there are much better ways to provide the services people need. The key will be to apply the clear lessons about how to do it.

I have been the Chief Executive of Bridge Mental Health since 2009. Our services are provided in south-east London through the assessment, recovery and community integration of people with mental health problems. The name 'Bridge' has its origins in the need for people with mental health problems to be supported once they leave hospital. This service is a 'bridge' between people leaving hospital and re-establishing themselves safely in the community. Our referrals come from low- and medium-secure hospitals, community mental health teams and, increasingly, from people referring themselves, drawing on the personal budget that is allocated to them by the local authority. Bridge Mental Health is funded by the NHS, clinical commissioning groups and local authorities, and we provide housing management support which is funded through individual rents.

One key success is our work with people who would otherwise be 'stuck' in a hospital inpatient ward. Public money is saved when we are able to move people safely into our community services from hospital. For example, the NHS provides a low to medium mental health secure unit service at £140,000 a year per person:

ABOUT BRIDGE MENTAL HEALTH

- Founded in South East London 28 years ago
- A charitable organisation and leading provider of mental health support services
- It has established a clear, proven pathway for people with long-term mental health problems to live well in the community
- In the past 3 years, its forensic service has expanded from 11 to 18 residents and it has secured new contracts for intensive and medium support
- Runs a unique Recovery College in the heart of the community
- Skilled and dedicated staff with expertise in recovery support

> "We had to make sure that the stigma of having a mental health problem was challenged at every turn"

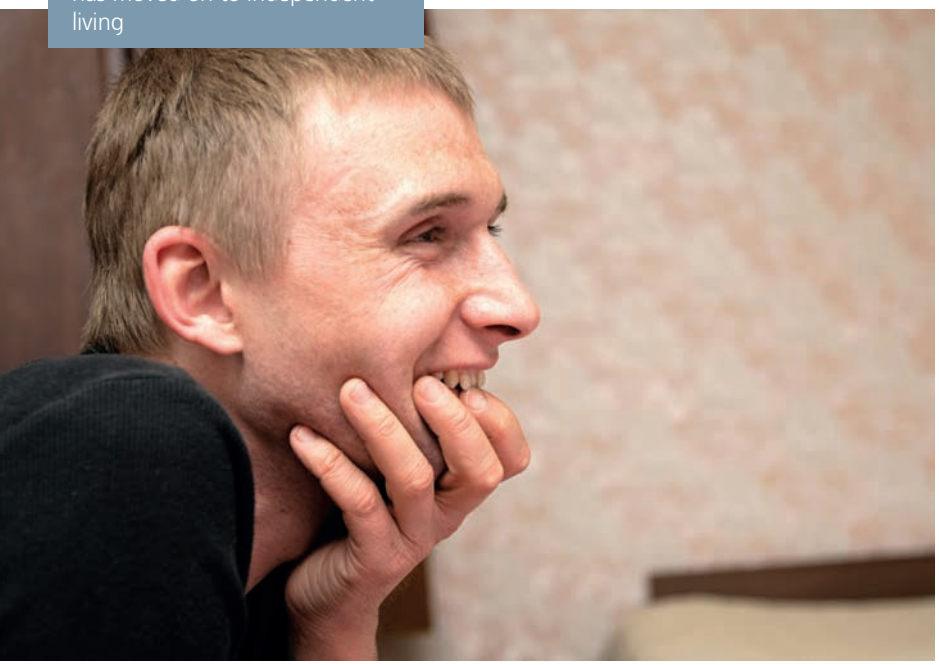
Bridge provides 24-hour specialist community mental health forensic support service for £70,000 a year. The NHS average cost for a mental health patient having two admissions to an inpatient mental health unit per year comes to £24,800. Bridge provides visiting mental health support for 2 hours a week to that person for £3,120 a year.

In 2009 we saw between 60 and 70 people every year. Today we are in contact with over 500 people a year, and will reach 1,000 people in the next 12 months. We are now winning substantial contracts and recognition from the Royal College of Psychiatry in the achievement of the Enabling Environments quality award. Bridge is also one of the first third-sector organisations to open a Recovery College, and this is providing support and training to over 450 people with mental health problems. Much of the support and training is delivered by peer trainers who have had previous mental health problems.

When I arrived in 2009, Bridge was failing, with only months to survive. There was a simple choice to be made. People could stay and fight for the organisation to succeed or they could move on and make way for new people. For those who stayed, the clear lesson was that we had to create a culture where everyone involved in Bridge would from then on be treated as equal partners. We had to make sure that the stigma of having a mental health problem was challenged at every turn. Where mental health was treated as a 'second class citizen' compared with physical health, we had to promote the view that achieving recovery for people with mental health problems was only possible when their mental health was taken as seriously as their physical health.

We use this approach when we work with the NHS, the clinical commissioning groups and the local authorities. Notable successes have been achieved only when there has been genuine integration between the health and social care partners doing what they do best, working in partnership towards the same ends. Measuring our outcomes over the past 10 years, Bridge has achieved a reoffending rate below 5% in our community ex-offender service as a direct result of the outstanding partnership working between Bridge, the NHS clinical teams, the Ministry of Justice, probation services, local housing teams and the police.

To develop an organisation that has a collective determination to do things better time after time, you need some basic principles on which everyone can agree. These include common values, and putting service users and their needs and safety first. But in the complexity of running any organisation that provides services for people who need support, it is the essential ability to work with people in a compassionate and caring way that is the most important part of all of our work. The success of our organisation is in the quality of the one-to-one interaction that our support workers have with the person they are



Floating support services – Tom has moved on to independent living

» TESTIMONIALS

'The quality of the support delivered has been excellent. The economic argument is a powerful one, comparing the costs of placement in secure hospitals with the services provided by Bridge.' (NHS Mental Health Commissioner)

'Bridge have been a great support for me. I was very withdrawn and depressed. With the help of Bridge and the staff, I've managed to get back on my feet.' (Muriel)

supporting. When we get this right, we get the culture right.

The leaders at Bridge also have a clear focus on always trying to shorten the distance between the management and the front-line staff. This is not just jargon. It means that faster and better decision-making can take place between leaders and staff. We will also be quicker to recognise mistakes and therefore act quickly to make improvements. The Francis Report made it clear that leaders in Mid-Staffordshire had lost touch with the front-line. When you combine the absence of staff behaving in a caring and compassionate way and the leaders who are distant from staff at the front-line of services, the fatal consequences become clear for all to see.

Leadership has a vital role to play not just in reinforcing the culture but in making sure that the strategy and aims of the organisation are clear. Our aims and objectives as a charity also give us clear, unambiguous direction in what we are trying to achieve. For Bridge, our objective is to help people with mental health problems by providing the support, the housing and the opportunities people need to become more independent. This means that we are always mindful that the effectiveness of organisations like ours can be measured by the perhaps

Supported accommodation – Ann receives support in her home

counter-intuitive fact that success is when people move on from our services and need less of our support. The last thing we want is for people to become permanently dependent. Success may mean that they no longer need us at all. The financial benefits to society are clear when people are able to move on to independence.

The governance, the systems and the measurements of success or failure of the organisation have had to be robust, clear to everyone and proportionate to the type of organisation we operate. Measurement has been kept simple so that anyone looking at us would be able to tell how well we are doing in meeting our goals. Have people moved on? Have they become more independent? Have they reoffended less than any other comparable service?

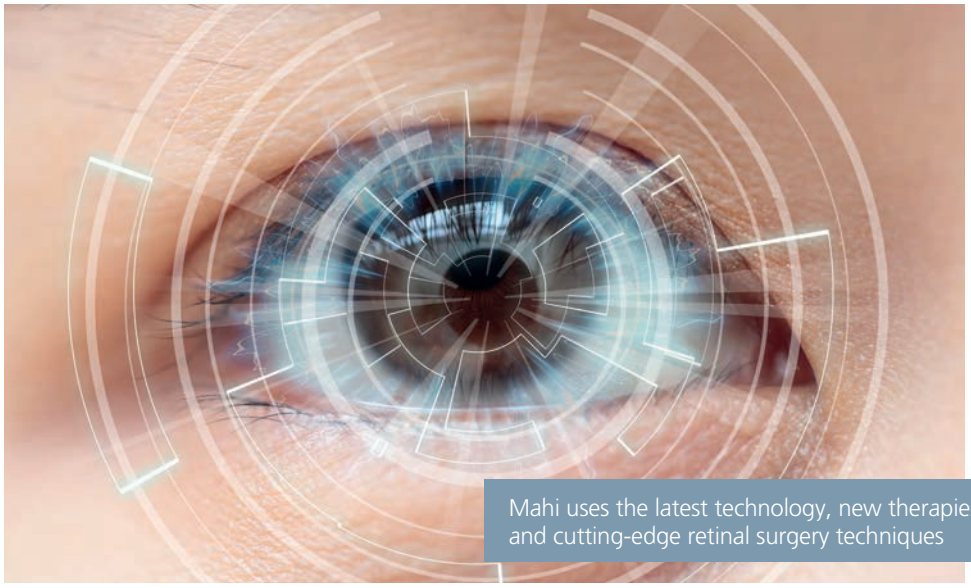
My hope is that the hard-won lessons of recognising the benefits of an equal status for mental health problems and the opportunities to achieve significant health, social and financial benefits through health and social care services really working together may be of value to anyone who is genuinely interested in transforming the way we deliver services both now and in the immediate future.

Women-only service – Eloise finds her confidence is built by working with her support worker

Mahi Muqit PhD FRCOphth

Consultant Ophthalmologist, Cataract and Vitreoretinal Surgeon

Mr Mahi Muqit BSc MBChB PhD FRCOphth



Mahi uses the latest technology, new therapies and cutting-edge retinal surgery techniques

ABOUT MAHI MUQIT

- Consultant Ophthalmologist and Cataract and Vitreoretinal Surgeon
- International reputation
- Private practice locations: Moorfields Private in the City, John Saunders Suite; Moorfields Purley, Purley Memorial Hospital; 119 Harley Street, The London Clinic, central London
- NHS practice at Moorfields Eye Hospital
- Offers pioneering new eye treatments and minimally traumatic cataract and retinal surgery
- Specialises in advanced retinal imaging and pioneering new retinal laser techniques
- Active in research and global charitable causes

With the 'bionic eye' electronic-chip surgery, gene therapy and stem-cell treatments appearing on the horizon for patients with blinding retinal conditions, the future is exciting for vitreoretinal surgery. Novel eye injection and laser therapies are continually being introduced that help achieve excellent visual outcomes for patients for many eye conditions.

Mr Muqit has established a leading private practice in London, and patients in the UK and from overseas have all benefited from the expertise and excellent surgical performance of this Consultant Ophthalmologist and Cataract and Vitreoretinal Surgeon, who is based at Moorfields Eye Hospital and at 119 Harley Street. In his practice Mr Muqit uses the latest technology, new therapies and cutting-edge retinal surgery techniques. His patients receive the latest treatments and benefit from excellent clinical care and benchmarked visual outcomes.

In 2014, Mr Muqit was the first surgeon at Moorfields Eye Hospital to perform combined femtosecond laser-assisted cataract surgery (FLACS) and vitrectomy for macular hole. In the FLACS procedure the cataract is melted using a laser, removed and a new custom-built lens implanted. The micro-thin membranes are peeled permanently from the surface of the macula. This minimally-invasive new approach to laser-assisted cataract surgery ensures that complications are rare and gives the patient a greater chance of preserving vision. In terms of recovery, patients are only required to hold their head in position for 24 hours after this surgery, and the FLACS procedure enables a shorter healing period after surgery.

In addition, Mr Muqit was the first UK vitreoretinal surgeon to use the innovative, intraoperative optical coherence tomography (iOCT) device for NHS patients having

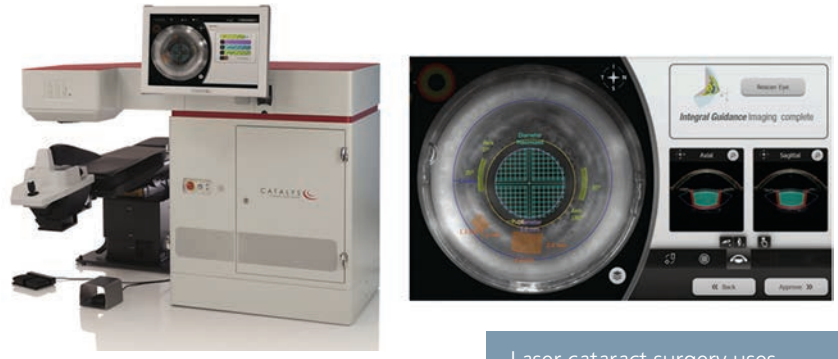
retinal surgery at Moorfields Eye Hospital. This pioneering technology enables the performance of precise and complication-free surgery for patients.

Moorfields Private is the UK-based private division of the world-renowned Moorfields Eye Hospital NHS Foundation Trust, a centre of excellence for providing pioneering ophthalmic care to patients from across the world – a tradition dating back to 1804. Mr Muqit has dual fellowship training in medical retina and diabetic eye disease, and vitreoretinal surgery. He specialises in advanced retinal imaging and pioneering new retinal laser techniques using the pattern scan laser (Pascal) photocoagulator in patients with diabetic eye disease. This extensive experience allows Mr Muqit to provide comprehensive clinical and surgical solutions for patients with disorders of the retina.

With a highly specialised consultant team of outstanding clinicians, leaders and surgeons, the vitreoretinal service at Moorfields Eye Hospital is recognised nationally and globally as a centre of excellence. It is the busiest and largest tertiary centre in the UK, and operates a renowned vitreoretinal emergency service in London. Many international and UK consultant vitreoretinal surgeons have been trained at Moorfields, and the centre continues to attract the best doctors from the UK and overseas for surgical training and research. Patients receive outstanding surgical care, and Moorfields Eye Hospital is often the choice of many patients seeking a second opinion on complex vitreoretinal surgical conditions.

Eye conditions treated

Mr Muqit works with pioneering new treatments and minimally traumatic surgery that provide high-quality visual results for his patients without additional risk. The latest minimally invasive vitrectomy surgery (MIVS) is used to remove the vitreous gel with self-sealing micro-incisions. The surgery is painless, takes around 20 minutes, and the recovery after the procedure is much faster than with conventional surgery, with less pain and swelling.



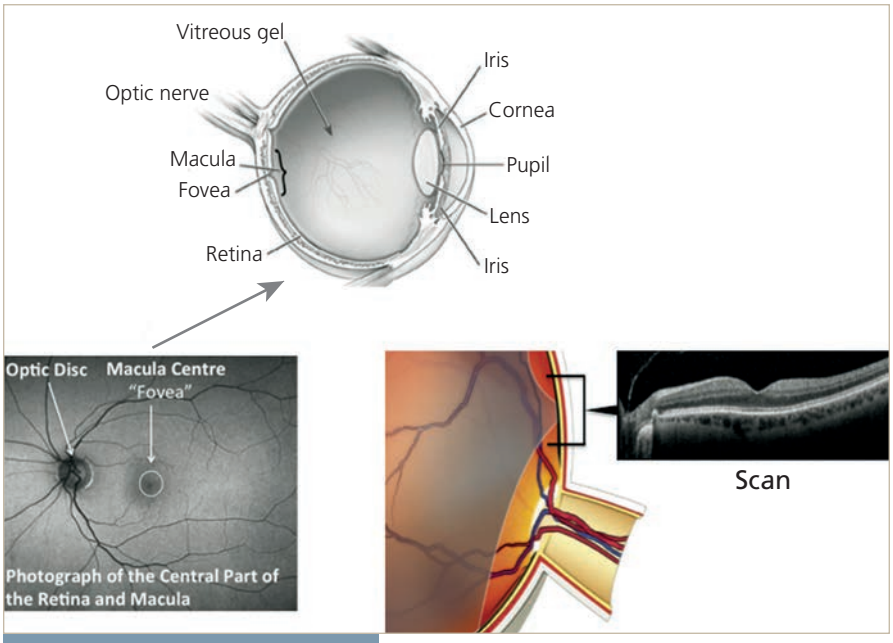
Laser cataract surgery uses LIQUID OPTICS technology

If the vitreous gel is pulling on the central part of the macula, a condition known as vitreomacular traction may develop, which causes blurring of central vision or distortion. The next stage is the formation of a tiny hole in the central macula, and then the central vision can suffer. Patients in whom these conditions have not naturally resolved over time can benefit from a single injection of a new treatment known as intravitreal Jetrea (ocriplasmin), which is licensed for UK patients. This drug liquefies the vitreous gel and releases it from the surface of the macula. Symptoms can significantly improve within 4 weeks without the need for surgery.

> “Mr Muqit uses the latest technology, new therapies and cutting-edge retinal surgery techniques”

Mahi Muqit is a member of the following leading societies:

- General Medical Council: Specialist Register
- Royal College of Ophthalmologists (RCOphth)
- Co-author and member of the Expert Panel for the Diabetic Retinopathy Guidelines 2012, published by RCOphth, London
- British and Eire Vitreoretinal Society (BEAVRS)
- UK and Ireland Cataract and Refractive Surgery Society (UKISCRS)
- Working Group for Diabetic Retinopathy with the International Agency for the Prevention of Blindness (IAPB)
- Diabetic Eye Care Committee for the International Council of Ophthalmology (ICO)
- Adviser to the Helen Keller International
- Specialist Adviser to the National Institute for Health and Care Excellence (NICE) for the Interventional Procedures Programme



Normal anatomy of the eyeball and optical coherence tomography retinal scan

The most common macular and retinal condition that is treated with laser is diabetic retinopathy. Mr Muqit is a global expert on diabetic retinopathy and advises non-governmental organisations about diabetic eye screening programmes. Reassuringly for patients, he developed the national laser guidelines for diabetic retinopathy in the UK. New minimally traumatic laser therapy can now be used to treat the retina effectively in diabetic patients, and this can minimise any bleeding complications and help patients maintain their ability to drive. Mr Muqit has published on this procedure as part of his clinical research studies, and he is recognised by his peers in the field of medical retina.

» RESEARCH WORK AND ACHIEVEMENTS

Mr Muqit devotes his time across the NHS, private sector, research and global charitable causes. He is a volunteer consultant for Helen Keller International (HKI) and is involved with innovative diabetic retinopathy screening programmes in the developing world. He is regularly invited to conduct external quality and assurance visits and training workshops for such projects. In Bangladesh, the first and only diabetic eye-screening centre has been set up, with HKI, at the National Institute of Ophthalmology in Dhaka, funded by the Lavelle Fund for the Blind. Currently, he is working on a joint Standard Chartered Bank funded and Seeing Is Believing Innovation Grant project 'Quality Improvement of Image Grading' with the Clinical Director of the English NHS Diabetic Eye Screening Programme.

Over 13 years, he has published over 50 articles in scientific journals and is a recipient of the European Young Ophthalmologist Award. Mr Muqit has worked on clinical trials and national epidemiology/surveillance studies, and is regularly invited to speak at UK and international scientific meetings. In recognition of his achievements in the medical sector, in 2015 Mr Muqit was presented with the prestigious British Bangladeshi Power & Inspiration Award at a ceremony in London.

» TESTIMONIAL

Medical Director, Moorfields Eye Hospital (2014)

'Mr Muqit is well recognised as an effective clinical leader and leads a large multi-disciplinary team, providing care for patients needing vitreoretinal surgery and medical retina treatment at Moorfields Eye Hospital.'

Giving the patient time

Patients need time to discuss their eye problems with an eye specialist and to fully understand the possible implications of their condition for their family life, job, studies, hobbies and, in particular, their ability to drive. Before embarking on a major eye operation or starting treatment, it is always worthwhile to seek a second opinion to discuss the risks and benefits in more detail. In consultations for a second opinion, Mr Muqit gives patients the time to appreciate the implications of their eye problem and understand the value of treatment. Patients are offered a potential solution that is based on current ophthalmic evidence and research, and receive a full explanation of any operation or treatment necessary. For some patients the consultation shows that no treatment is required. If patients are found to have an eye problem that cannot be managed within Mr Muqit's subspecialty, he will ensure that they are swiftly referred directly to a specialist colleague at Moorfields Eye Hospital to ensure that continuity of care is maintained to the highest standards.

Labour MPs rebel over welfare

The government's post election Welfare Reform and Work Bill caused dispute within the Labour party

The package of welfare measures and minimum wage increases at the heart of George Osborne's budget created havoc on the Labour benches. For many Labour strategists, the perception that their party was soft on welfare was an important factor in their election defeat. But faced with the sweeping cuts proposed by the Chancellor, Labour MPs were unable to unite around their acting leader, Harriet Harman, who wanted to abstain on the second reading of the government's Welfare Reform and Work Bill. This lowered the cap on how much a household can receive in benefits and limited child tax credits to two children per family – although it would only begin to apply to children born after March 2017.

The former social security minister, Helen Goodman, led the internal dissent with a 'reasoned amendment' to kill the Bill, which attracted the signatures of 60 Labour MPs. That forced Harriet Harman to propose her own amendment setting out which cuts Labour supported, but also seeking to stop the Bill.

In the ensuing Commons debate, the work and pensions secretary Iain Duncan Smith said his Bill would target the 'five key pathways to poverty that affect children's life chances: worklessness, educational attainment, drug and alcohol addiction, family breakdown and problem debt. The Bill will remove the existing measures and targets in the Child Poverty Act 2010 and introduce a new duty to report on worklessness and educational attainment … Our new approach will drive real action, which will make the biggest difference to the most disadvantaged children now and in future.' He visibly enjoyed the discomfort of Labour MPs.

For Labour, shadow work and pensions minister Stephen Timms supported some sections of the Bill but criticised the government for – as he saw it – dropping the ambition to reduce child poverty: 'Instead of eliminating the scandal of child poverty, the Bill attempts to eliminate the term.'

The other parties in the Commons opposed the Bill outright. The SNP's Hannah Bardell said it would push children and families deeper into poverty, and the Lib Dem Tim Farron, making his Commons debut as party leader, said the government did not have to take £12 billion from the poorest families in the country, but chose to do so.

Another important voice was that of the Labour chair of the Work and Pensions Select Committee, Frank Field. He said Labour should defend the three million 'strivers' who depended on

in-work benefits. They were 'walloped', he said, with many becoming £1,000 a year or more worse off.

But there was strong support from the Conservative side, where influential backbencher David Burrowes was jeered when he claimed membership of 'the workers and one nation party.' He said the Bill could also be described as the 'catch you when you fall Bill' or the 'lift you when you can rise Bill'.

Helen Goodman, whose rebel amendment had caused such difficulty for Harriet Harman, said the government had no mandate for the Bill: 'Throughout the election the Tories refused to say how they were going to save £12 billion from the welfare bill, because they knew that the measures would be unpopular and it would hit them in the ballot box.'

Another Labour MP, John McDonnell, was more graphic: 'I would swim through vomit to vote against the Bill … We hear lots about how high the welfare bill is, but let us understand why that is the case. The housing benefit bill is so high because for generations we have failed to build council houses, we have failed to control rents and we have done nothing about the 300,000 properties that stand empty in this country. Tax credits are so high because pay is so low. The reason why pay is so low is that employers have exploited workers and we have removed the trade union rights that enabled people to be protected at work.'

A split of 48 MPs caused Labour's amendment to the welfare bill to lose by 208 to 308 votes

By signalling a major change in welfare policy, the Bill had exposed a serious rift in Labour's ranks. In the end, 48 Labour MPs voted against it.

English votes for English laws

The Scottish independence referendum was a near-death experience for the 300-year-old union of England and Scotland – and after a poll showing the 'yes' side was in the lead, the main party leaders had issued 'the vow', a promise of extensive further devolution. But on the morning after the referendum result, David Cameron had also promised to address the English question – the growing resentment at an asymmetric constitutional settlement that allows Scottish MPs to vote on English issues but does not allow the reverse.

The ramifications of this issue, and the prospect of a minority Labour

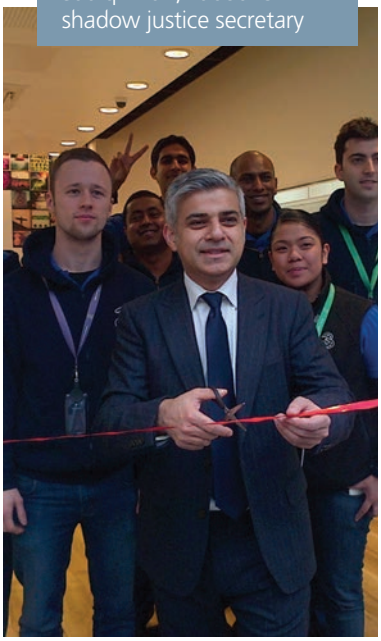
Scotland voted to stay in the UK after voters rejected independence

SNP and Lib Dem MPs warned that the proposal for 'English votes for English laws' risked turning the Commons into a quasi-English parliament

government sustained by the votes of SNP MPs, became one of the dominant themes of the 2015 general election. And the issue was previewed when the Commons debated a government document – a command paper – setting out the options for EVEL, or 'English votes for English laws'.

The options included a total bar on Scottish MPs voting on English and Welsh legislation, allowing English MPs a greater say during the early stages of consideration, and giving English MPs an effective veto at the committee stage of a Bill, and an English Grand Committee of the Commons, again with a veto over England-only legislation.

Sadiq Khan, Labour's shadow justice secretary



To the regret of the leader of the Commons William Hague, Labour had not engaged in the debate. 'It is an issue that too many people have avoided for too long and it can no longer be put aside,' he said.

Labour's shadow justice secretary Sadiq Khan warned against hasty action: 'what we must not do, only months after the Scottish people voted to keep our kingdom united, is allow the division of our country by the back door. Nothing we do should jeopardise the future of the Union … uniting our country is more important than uniting the Tory party.' That was a swipe at David Cameron, who faced criticism within his party for making too many concessions to Scottish demands – it had become increasingly clear that many of his troops would not support the promised further devolution for Scotland without action on the English question.

One of the key advocates of EVEL was the former cabinet minister John Redwood, who argued that major constitutional legislation was not needed, and that it could be brought in via a simple change to the standing orders of the House of Commons, on a single vote. He challenged Mr Hague: 'England expects English votes for English issues. We expect simplicity and justice now, no ifs, no buts, no committee limitations, no tricks. Give us what we want … Will he now join me in speaking for England?'

The Conservative 2015 manifesto included a detailed scheme for those standing order changes, to allow an effective English veto on legislation – and those proposals were confirmed in July. But when the former Scottish secretary Alistair Carmichael, a Liberal Democrat, employed a rarely used procedural device to secure an emergency debate on the proposals on 7 July, it became clear that a number of key Conservative backbenchers were deeply troubled by the implications for the future of the UK.

Mr Carmichael said the proposal was one no Unionist should advance: 'It is perfectly understandable for people in England to identify a national interest in response to the mood of Scottish nationalism forming north of the border, but the answer is not to meet it with more nationalism. The answer is, I suggest a proper federal structure.' He was interrupted by the Conservative Andrew Bridgen, who accused him of 'wanting to have his porridge and eat it'. Mr Carmichael insisted he understood that there was a problem: he simply didn't believe that the answer was 'trashing the Union and the United Kingdom parliament'.

The new leader of the Commons, Chris Grayling, insisted the central issue remained one of fairness: 'If members of the Scottish parliament are in future to decide a Scottish rate of income tax … is it actually unfair that English members of parliament, or English and Welsh MPs, or English, Welsh and Northern Ireland MPs have the decisive say over tax rates that affect their constituencies?'

But perhaps the most influential contribution came from the Conservative ex-minister Sir Edward Leigh, who crystallised the anxieties of some of his colleagues. He said votes on many ostensibly English issues had knock-on financial consequences for Scotland (known as 'Barnett consequentials' in parliamentary jargon). So, he warned, preventing Scottish MPs from voting on those issues would hand the Scottish nationalists a grievance they would exploit: 'Of course the SNP wants independence [cheers from the SNP benches] but why are we making it easier for them? …Why are we giving this gift to the SNP?'

For the SNP, Pete Wishart drew a lesson from history: 'What we are doing is quite extraordinary. We have not done anything like this for centuries. It is of historical significance because it is of such constitutional importance … Back in the days of Gladstone, this was being done in order to curtail the voting rights of Irish MPs, and history is able to judge how successful that was in maintaining the Union.' A point that attracted the support of the Democratic Unionist Ian Paisley, who warned: 'no-one can predict the crisis that could engulf Scotland, England, Wales and Northern Ireland as a result of what is happening here'. This was a crucial intervention because it made clear that the government could not rely on the DUP to bolster its slim Commons majority.

Sir Edward Leigh warned that Scotland must be handed 'home rule' to stop a 'toxic mixture' of circumstances destroying the union

Faced with evidence that a small but influential band of its own MPs would not support its proposals, the government retreated and promised a consultative debate, after which a refined version of the standing order changes will be voted on in the autumn.

Commons meltdown over the non-vote on the European Arrest Warrant

The issue of shared justice powers within the EU was one of the most sensitive of the 2014–2015 Parliament – and, in particular the European Arrest Warrant (EAW), seen as a vehicle for arbitrary arrest in Britain, at the behest of foreign courts, had attracted the opposition of Eurosceptics and civil libertarians. Britain had negotiated a blanket opt-out from EU justice and policing cooperation, but the deal also allowed the UK to opt back in to those powers where the government wanted to work with other member states. And

David Cameron has suggested MPs should 'move on' after the government's decision not to hold a parliamentary vote on rejoining the European arrest warrant

backbench critics of the EAW had been promised there would be a full-dress Commons debate on any UK opt-in.

But when that long-awaited debate came, it produced angry and sometimes farcical Commons scenes, when the Speaker ruled that the motion did not include the warrant at all. The home secretary Theresa May argued that the vote could be taken as 'indicative' of Commons consent for the EAW. She was rebuked by the Speaker, who said the government was 'trying to slip things through by some sort of artifice' and that the public was 'contemptuous' of such conduct.

The shadow home secretary Yvette Cooper piled in, mocking the government's tactics, as a 'shambles' and 'complete chaos' – but it was the language used by a succession of furious backbench Conservatives that would set alarm bells ringing in the government whips' office. The former minister Sir Edward Leigh asked simply, but devastatingly, 'What are we voting on?' Maastricht veteran Sir Bill Cash said the debate was 'tainted with chicanery'. Sir Richard Shepherd said the manoeuvre brought the Commons into disrepute. Jacob Rees-Mogg dismissed it as 'an outrageous abuse of parliamentary procedure … fundamentally underhand'.

There were repeated calls for the home secretary to explain herself, and when she rose to speak she showed considerable steadiness under fire as she insisted that the EAW did not require a vote because it was already on the statute book; the motion referred to the measures that did need to be transposed into British law. 'However, the government are clear that the vote that will take place on the regulations will be the vote that determines whether or not we opt into these measures.'

Labour, unusually, forced a vote on the motion, setting out the timetable for the debate – which led to a rebellion by around 30 government backbenchers, and the government motion was only just carried, by nine votes. In the debate proper, Theresa May warned that if the powers were not agreed, there would be an 'operational gap' on issues like extradition and international prisoner transfer, which would create real problems for law enforcement.

Yvette Cooper praised Theresa May for making an excellent defence of powers that were not referred to on the order paper: 'given that there is a majority in the House for the European Arrest Warrant, why on earth are we not voting for it. Why the sophistry, why the games?' And she tried an unusual procedural manoeuvre, by moving that the question 'be not now put.'

That was defeated and – with absent Conservatives answering an urgent summons to return to Westminster (the Prime Minister went through the division lobbies in white tie, having been called back from a Mansion House banquet) – the criminal justice measures were approved by 464 votes to 38. But the whole event left Conservative Eurosceptics deeply suspicious of their own leadership – a mood that persisted into the new 2015 parliament.

Bercow ambush

It was a cunning plan, a last minute ambush, intended to make Speaker Bercow more vulnerable to removal at the start of the 2015 Parliament. It backfired badly.

The final pre-election week of any parliament is usually devoted to legislative loose ends, resolving detailed disagreements between the Commons and the Lords about Bills still in the legislative sausage machine. This often involves motions being tabled and debates being scheduled at short notice – and so few eyebrows were raised when ministers pushed through a procedural motion allowing them to put new business before MPs, at short notice.

But in the early evening of the penultimate day of the parliament, the leader of the Commons, William Hague, visited the Speaker's office to inform John Bercow that the government intended to use those powers to debate changing the way that the Speaker was re-elected at the start of a new parliament. The current procedure is for MPs to shout 'aye' or 'no' to the motion that the incumbent Speaker resume the chair. Only if there is significant dissent is an actual division held, and in those circumstances the way each MP votes is a matter of record.

That, of course, is a significant deterrent to voting against a Speaker – MPs who support an attempt at removal, and fail, could face retaliation – not being called to speak, or only being called very late, for example. So, there was a democratic case for changing the rules – but this manoeuvre smacked of a coup against a Speaker who had been a thorn in ministerial sides, and who had made

William Hague wanted a secret ballot to decide the Speaker's future after the election

plenty of enemies on the Tory benches with his withering put-downs. More than that, Bercow's procedural rulings had frequently displeased ministers – and might present them with even greater problems in the event of a hung parliament.

Conservative MPs had been kept in Westminster for a party briefing. However, many Labour MPs had already left to start campaigning: if the rule change was to be blocked, they had to get back. So, to buy time, the Speaker allowed three urgent questions, using up a couple of hours before the house reached the government motion.

By that time, the Labour benches had filled up. William Hague was given a rough ride as he argued that the rule change was overdue, and that the government had simply seen a good moment to give MPs a chance to debate it. He was supported by Conservative MPs like Michael Fabricant – a strong critic of the Speaker, who invited him to 'pay tribute to Mr Speaker who, on 20 July 2000 and again on 23 April 2009, advocated the need for secret ballots to

stop government whips "browbeating" MPs as to the way they might vote'.

But Mr Hague must have been wounded by the furious response from his Labour shadow, Angela Eagle, who said the leader of the House was supposed to defend MPs' rights: 'I am sorry to say that by supporting this grubby little plot against the Speaker on his last day as a parliamentarian, the leader of the House has failed in his duty.' Other MPs used phrases like 'stitch up' and 'grubby schoolboy intriguing'.

As a noisy, angry hour of debate continued, the killer blow came from a Conservative, Charles Walker, an ally of the Speaker and member of the powerful executive of the 1922 Committee, which represents Tory backbenchers. Crucially, he also chaired the Commons Procedure Committee. The anger felt across the chamber seemed to take form around him as he complained that he was not consulted about a debate on one of his committee's proposals – and he recounted how he'd attended end-of-term parties and farewell drinks where there had been plenty of opportunity to tell him what was planned.

His peroration – delivered with considerable emotion – was devastating: 'I have been played as a fool. When I go home tonight, I will look in the mirror and see an honourable fool looking back at me. I would much rather be an honourable fool, in this and any other matter, than a clever man.' For the only time in a difficult debate, William Hague's composure cracked. Many Conservative MPs were tearful. Labour MPs delivered an unprecedented standing ovation. In that moment the motion was clearly lost – and Charles Walker became the likely successor to Mr Bercow.

And the sequel, when the Commons met, after the May 2015 General Election, was that the new Conservative government did not orchestrate a challenge to the Speaker. Mr Bercow was re-elected with no opposition at all.

Assisted Dying Bill

Rule changes that would give terminally ill patients the right to die was rejected by the House of Commons

Attempts to change the law to allow terminally ill people to end their lives have cropped up regularly in the House of Lords in recent years – but the latest, the Assisted Dying Bill, proposed by a Labour peer and former Lord Chancellor, Lord Falconer, has proved the most serious yet. Private members' Bills in the Lords seldom have much realistic prospect of becoming law, but this one produced a series of passionate and emotional debates.

Some of the most striking speeches came during detailed debate – when the crossbench or independent peer Lady O'Neill tried to change its title to the Assisted *Suicide* Bill. She said it was about aiding and abetting suicide, and just as truth in advertising was essential, so was truth in legislation.

She was supported by the Labour peer Lord Brennan – who said the language had to be brutally clear, and the clearer the law the better the decisions people would make.

A powerful riposte came from the Labour peer Lord Cashman, who described how his partner of 31 years had died of cancer. His voice shaking with emotion, he said the circumstances of his loss shed some light on the question – in his distress he had wanted to commit suicide; his terminally ill partner had needed to have his death accelerated. That was an important distinction.

The crossbencher Lord Pannick, an eminent human rights lawyer, said the idea that the public would not understand the Bill's terminology was simply fanciful. But the Labour peer and doctor Lord Winston disagreed – elderly, confused, angry, distressed and perhaps even deranged patients who arrived in hospital needed as much clarity as possible, he said.

Lord Deben, the former Conservative cabinet minister John Gummer, said the Bill's terminology should be stark, not soft – and the hearer needed to hear the word 'suicide', not 'assisted dying'. But Lord Low, vice president of the Royal National Institute of the Blind, suggested the real aim of the amendment was to give assisted dying the same stigma as suicide. He thought the latter word was inappropriate to describe the rational choice of a mentally competent, terminally ill person seeking a dignified, peaceful death.

The Conservative veteran Lord Tebbit produced a copy of the *Oxford English Dictionary* and quoted the definition it gave: '"Suicide, the act of taking one's own life – self murder". Can we settle the matter now?' Another Conservative, Lord Dobbs, retorted that to end one's life in a process involving

Baroness Campbell of Surbiton

doctors, nurses and a judge was not killing oneself.

The most powerful attack came from the disability campaigner Baroness Campbell of Surbiton – who has spinal muscular atrophy. Speaking from her wheelchair, she said that like many people with disabilities she had experienced long periods of depression, 'but then things could get better. When you, and if you, get through that period … If in my case a new ventilation system is developed, you get better again. Maybe you have a week, or a month, or as in my case another 2 years. But during that weary low time when everyone is expecting that this is the time that you are going to die, you could easily take advantage of an assisted dying exit.'

The House listened in utter silence as she said she'd taken important decisions in those low periods. She had not taken a pension because she had always expected to die – and her request that peers remember that when she asked for a free lunch produced a muted, rueful gulp, rather than a giggle from peers.

But the House voted to reject both the attempt to change the title of the Bill and another amendment for more restrictive rules on assisted dying. And both votes underlined the strong support it has now built up in the Lords. In the end, the Bill ran out

of debating time, but its supporters believe the extensive debate, and changes, including the addition of judicial oversight to the process, have produced a well-honed proposal that can be laid before the new parliament, for another attempt to write it into the statute book.

The first Euro-rebellion of the 2015 parliament

The European Union Referendum Bill caused unease within the Conservative party

The sequel to the 10 November 2014 row over the European Arrest Warrant was played out when the Commons came to debate the detail of the new Conservative government's European Union Referendum Bill – when it became clear that many Eurosceptic Conservative backbenchers harboured deep suspicions of their own leadership.

The Bill would have allowed a vote on British membership to be held in parallel with the May 2016 elections – which will include the elections for the Scottish parliament and for the mayor and borough councils of London. And it also included a relaxation of the normal 'purdah' rules, which restrict government activity that might influence the result in the run-up to an election or referendum.

Both of these could be – and were – seen as an attempt to bias the referendum in favour of the pro-EU side: London and Scotland were seen as pro-EU areas, where extra turn-out driven by their elections could produce additional votes for the 'yes' vote, and the relaxation of purdah would have allowed, Eurosceptics feared, the whole weight of the government machine to be thrown behind the 'yes' campaign.

Before the committee stage debate began, the government had announced the referendum would not be held alongside the Scottish and London elections – which left purdah as the main bone of contention. The Europe minister David Lidington wrote to MPs, arguing that the purdah rules could inhibit ministers in carrying out the day-to-day business.

But as the debate began, the former SNP leader Alex Salmond, newly returned to Westminster and now his party's foreign affairs spokesman, predicted a re-run of the events that he believed had swung the 2014 Scottish referendum against independence. 'Let us just assume that, to try to get the "yes" result that the Prime Minister wishes, he needed a last-minute initiative. With no rules or restrictions saying that new political initiatives should not be made at governmental level during the last 28 days of the campaign, what would stop the Prime Minister doing a tour of the capitals of each of the governments across Europe – suspending Question Time in

the national parliament – and stop their flying as one to London to announce a new commitment, a new undertaking, a new pledge, a new vow?'

The Conservative and former defence secretary Liam Fox said it was 'unseemly at best' for the government to exempt itself from the normal pre-election restrictions – underlining that it was essential that the referendum process was seen as fair. He noted that he had never, in 23 years in parliament, defied his party whip, and he urged the government not to force him to do so on this Bill.

In response, Mr Lidington said the government would exercise 'restraint' during the referendum campaign, and he promised to bring forward new amendments at the next stage of consideration of the Bill – the report stage – in September. Crucially, this was enough to ensure that Labour would not back rebel Conservatives, allowing them to defeat the government.

But a rebel amendment from the veteran Eurosceptic Sir Bill Cash was pushed to a vote – and, although it attracted only 27 Conservatives, no one missed the significance of the moment. The Conservative Eurosceptics had demonstrated that they had the numbers and the will to defeat the government – if the other main opposition parties lined up alongside them. So, the government avoided embarrassment only because Labour did not take sides against it. With a new Labour leader due to be elected in the autumn, ministers cannot rely on similar support in future.

Danny Alexander's last stand

Until 7 May, Danny Alexander was one of the four most powerful members of the coalition government. As the Lib Dem's man in the Treasury, he sat on the Quad – the key committee coordinating coalition business, alongside David Cameron, George Osborne and Nick Clegg. As the number two minister in the Treasury he was a co-author of the final coalition budget, delivered on 18 March by Chancellor George Osborne. And the following day, with an election looming, and pressure to put clear yellow water between the Lib Dems and the Conservatives, it fell to him to deliver a Commons statement entitled 'Fiscal responsibility and fairness', which was billed as his party's alternative budget. The attempt was not a success.

Even before Mr Alexander began, the Speaker, John Bercow, intervened, to make clear that any ministerial statement had to be made on behalf of the whole government, not just one component of it. He said it would be unfair to the House for a minister to use his privilege for party purposes, and would put the chair in an awkward position.

The chief secretary did attempt to unveil an alternative economic vision to that of his coalition partners: 'Today I set out a better economic plan for Britain … based on values of fairness as well as strength … [that] enables our country to see light at the end of the tunnel. It is not a rollercoaster ride, but a steady path back to prosperity. It sticks to the path we have chosen in this government, rather than lurching away from it by cutting too much or borrowing too much.' Essentially, he unveiled the middle-way campaign theme his party then used throughout

Danny Alexander's 'Yellow Budget' was poorly received

the general election, but as a piece of parliamentary theatre the speech was a failure.

Mr Alexander was never a great parliamentary orator, and was heckled mercilessly by Labour MPs. At one point, the Labour front-bencher Andrew Gwynn threw a copy of the coalition budget book onto the table in front of the chief secretary. He cut a lonely figure at the Dispatch Box. Only a handful of Lib Dem MPs had turned out, and there were catcalls, jeers and shouts of 'bye' from Labour when his leader, Nick Clegg, left the chamber while Mr Alexander took questions.

Labour's Treasury spokesman Chris Leslie was withering: 'doesn't he realise how two-faced he looks'. He complained that the statement was an abuse of the procedures of the Commons.

There was no official Conservative response – but the backbencher Adam Afriyie pulled no punches: 'I have to say that I am stunned by this statement … This is the Westminster bubble at its absolute worst, and it represents everything that is wrong with politics today. The Liberal Democrats have betrayed their voters, and their voters know it; their own candidates are now pretending to be independents; and today's display is an absolute betrayal of the role they have played in government.'

A bruised Mr Alexander staggered to the end of his statement. Whatever the virtues of the policies he announced, they did his party little good. Seven weeks later he was out of parliament, a casualty of the SNP landslide in Scotland, and his party was reduced to a rump of just eight MPs.

A Queen's Speech for working people from a One Nation Government

The Queen outlined the one-nation programme of the first majority Conservative government in two decades

It was a tale of the unexpected; after an election campaign dominated by speculation over the possibility of a hung parliament, David Cameron's Conservatives were now in government in their own right, with a modest but definite majority.

Their Queen's Speech was the first purely Conservative programme for government since the distant days of John Major. Conservative MPs – whose number included plenty of new faces – were jubilant. Labour, which almost till the last had expected to be in government, not opposition, was in crisis. The Liberal Democrats were reduced to a remnant, and the SNP had taken over as the third party in the Commons, forming a confident, sometimes noisy phalanx in a corner of the chamber, where a lively border dispute with Labour MPs became one of the running themes of the early weeks of the new parliament.

One sign of the change was the appearance of Labour's Harriet Harman to speak for her party. Five years before, she had been acting leader after the departure of Gordon Brown; now she was filling in again, following the resignation of Ed Miliband.

Recalling David Cameron's admission that he would not seek a third term as Prime Minister, she remarked that they were both interim leaders – and she promised the Conservatives that, with such a slender majority, they would not have everything their way. But there were ironic cheers from the government side as she confirmed that Labour had dropped its opposition to a referendum on the UK's membership of the EU: 'We believe that it will be better for Britain if we stay in the European Union. It is important for the future of this country, which is why 16- and 17-year-olds should have the right to vote in the referendum – it is their future, too.'

She warned that the economy, the constitution and public services remained in a fragile state and that the benefits of returning economic growth were not being shared. 'Britain cannot succeed with low-skilled, low-wage, insecure employment and a race to the bottom. The path to economic prosperity and recovery must involve a high-skilled, long-term approach.' She added that Labour was sympathetic to another key government policy, the idea of a new cap on annual household benefit payments.

On the constitution, she said any change to 'English votes for English laws' should be built on the 'broadest possible consensus'. And she took a swipe at the SNP MPs, who all but wiped out Labour in their former Scottish heartland: 'Of course the Scottish National party wants to break up the Union – it wants people to have to choose between being Scottish and being British – but it would be utterly irresponsible for the Prime Minister to continue what he did so shamefully in the general election, which was to set the English against the Scots … Let us be in no doubt: the worst possible outcome for Scotland would be the SNP demanding full fiscal autonomy, which they know does not add up, and a Tory Prime Minister giving it to them.'

The Prime Minister did not fail to notice the attendance of former SNP leader Alex Salmond in the Commons

David Cameron began his response with a barbed welcome for Harriet Harman's return as acting Labour leader. And he noted the presence of the former Scottish first minister, Alex Salmond, back on the SNP benches: 'I notice that he is now the foreign affairs spokesman for his party – for which I assume he speaks on issues relating to England, Wales and Northern Ireland.'

He said the last parliament had been about a 'repair job' on the UK economy, and this one would be about 'renewal'. 'This is the Queen's Speech for working people, from a one nation government that will bring our country together. We have a clear mandate from the British people, a long-term economic plan that is working, a detailed and compelling manifesto, and we will not waste a single moment in getting on with the task,' he said.

He announced that the government would legislate immediately for an EU

membership referendum and would then embark on negotiations to reform Britain's membership terms. And while he welcomed Labour's support for the referendum, he noted: 'If we had listened to the Labour Party there would be no renegotiation and there would be no referendum; there would be no choice.'

As Deputy Prime Minister the Liberal Democrat leader Nick Clegg had sat alongside David Cameron on the government front bench. But the election reduced his party to just eight MPs – that meant he had to sit on the backbenches and wait quite a while for the opportunity to deliver his thoughts: 'my party's parliamentary presence may be much reduced in size, but our mission is clearer than ever. As we did in the coalition government, we will fight any attempt to weaken the fundamental rights of our citizens, whether those enshrined in the European Convention on Human Rights and the Human Rights Act, or those threatened by what sounds, from what I have heard today, to be a turbo-charged snoopers' charter.' These themes were to unfold over the early weeks of the new parliament.

The new government's first budget

Chancellor George Osborne's focus was on cutting the welfare bill by £12 billion and boosting employment and productivity in Britain

It was George Osborne's seventh budget, but his first completely Conservative one. And its sheer radical sweep left political parties and interest groups struggling to catch up.

The central element was a series of radical cuts to in-work tax credits, new restrictions on housing benefit and a reduction in the annual benefit cap to £23,000 a year per household in London and £20,000 in the rest of Britain. These measures were partially compensated for by a new £7.20 an hour national living wage for workers aged over 25 – an audacious raid on Labour's election manifesto. It will come into force in April 2016 and rise to £9 an hour by 2020. As it was announced, the work and pensions secretary Iain Duncan Smith could be seen punching the air in delight. And as Conservative MPs cheered, Mr Osborne repeated the announcement with theatrical flair – in case Labour MPs hadn't heard it the first time.

The Chancellor hailed his proposals as a budget for working people 'that sets out a plan for Britain for the next 5 years to keep us moving from a low-wage, high-tax, high-welfare economy to the higher wage, lower tax, lower welfare country we intend to create'. He said the budget was the product of a 'one nation' government, which had been entrusted by the British people to rebuild the economy on a stronger footing. And he pointed to the unfolding crisis in Greece as a warning of what could happen

if this country failed to deal with its borrowing.

One key announcement was that he would continue to cut the deficit at the same pace seen in the last parliament – a pace that would see the UK move to a surplus in the 2019–2020 financial year. That promise was underpinned by a series of measures, including the decision to restrict public sector pay rises to 1% per year, to replace student maintenance grants with loans and to abolish permanent non-domiciled tax status.

These measures would also allow the government to meet NATO's annual defence spending target for member nations, of 2% of GDP. The threat that Britain might not meet that requirement had caused considerable disquiet on the Conservative benches – so the announcement was greeted with some pleasure there.

When the Chancellor sat down there were ecstatic cheers from Conservative MPs, who sensed that he had produced an economic package with real voter appeal, and one that wrong-footed the opposition. Labour's acting leader, Harriet Harman, promised to look constructively at proposals to cut welfare spending. But she warned that the new national living wage would not make up for the cuts to tax credits, and many families would suffer as a result. And she added that the budget was 'less about economic strategy and more about political tactics to help him move next door [from 11 Downing Street to the Prime Minister's residence, No. 10]'.

The responses from a slightly punch-drunk House of Commons reflected the need to fully digest an unusually complicated and far-reaching financial package. The newly re-elected chair of the Treasury Select Committee, the Conservative Andrew Tyrie, suggested that the recent electoral 'bidding war' had reduced the Chancellor's room for manoeuvre, leaving too much of government spending ring-fenced from cuts, and he had not made his job any easier by tying his hands on tax, by legislating to prevent increases to the main taxes. But he thought this budget, the forthcoming spending announcements in the autumn statement and the budget next year would, taken together, provide a real opportunity to secure the economic revival of Britain.

The UK will have a surplus of £7 billion in 2019–2020, according to projections from the Office for Budget Responsibility

The Chancellor pledged to meet NATO's target of spending 2% of national income on defence every year, up to 2020

A less favourable assessment came from the SNP's finance spokesman Stewart Hosie, who said that the Chancellor had been wrong to suggest that people living on benefits were making a 'lifestyle choice' even if they were trying hard to find a job: 'their lifestyle choice is to work, and they should not be denigrated by someone who has never been short of a bob or two'.

MPs remember Charles Kennedy

Harriet Harman led the tributes in the Commons following the passing of Charles Kennedy

For the victorious parties in the 2015 general election, the first few days of the parliament were celebratory – but the mood was punctured by news of the untimely death of a Commons star. The former Liberal Democrat leader Charles Kennedy had lost the highland seat he'd represented since 1983, and on Tuesday 2 June the morning bulletins carried the news that he'd been found dead at his home.

The Speaker led the ensuing Commons tribute session, his voice cracking with emotion: 'Charles had the rare ability to reach out to millions of people of all political persuasions and of none … who were untouched by, and in many cases actively hostile to, politics. In this seminal sense, therefore, Charles was the boy next door of British public life.'

Mr Kennedy's former wife, Sarah, and their 10-year-old son, Donald, were in the visitors' gallery above the government front bench. Donald's strong resemblance to his father added another layer of emotion to an already highly charged occasion. David Cameron spoke next, quoting Mr Kennedy on dealing with the voters: '"the vast majority of people think there's a hell of a lot more to life than just politics,"' … At his best he was the best that politics can be, and that is how we should remember him.'

Labour's acting leader Harriet Harman recalled what was probably the peak of his national influence – when his party opposed the 2004 Iraq invasion: 'He was right, but he never felt the need to denigrate those of us who got it wrong … He was partisan, but he was still generous enough to admire people in other parties … I remember when he first came to this House, aged only 23 – the golden boy from the Highlands. He shone in this chamber.'

Nick Clegg, the former Lib Dem leader, who entered parliament when Mr Kennedy was still the party leader, said Mr Kennedy was brave, yet vulnerable – brilliant, yet flawed. 'There was a steely courage about him, most memorably on display when he took the principled decision to oppose the Iraq war. Just because that might seem now an obvious thing to have done, it most certainly was not at the time. Charles was often a lone voice in this House, standing

up against a consensus on all sides in favour of war. The fact that he was proved so spectacularly right is a tribute to his judgment and his intuitive common sense.'

Angus Robertson, the Westminster leader of the SNP, revealed a surprising conversation: 'While I and my colleagues were delighted that the SNP won Ross, Skye and Lochaber, I was saddened Charles Kennedy would no longer be in parliament. It is a mark of the man that when I got in touch with him after the general election, he readily agreed to meet up and share his experience of his leadership of the Liberal Democrats when it was the third party in the House of Commons.'

Ian Blackford, who won the seat for the SNP, recalled him as a generous opponent in his earlier, unsuccessful run against him: 'I remember Charles turning to me and consoling me. Rather than putting the boot in … That was the mark of the man: a decent, human man, who saw the struggles that others were going through.'

But – as Charles Kennedy himself had acknowledged – he had a problem with alcohol. A tragic illness, said another Liberal Democrat colleague, Norman Lamb. 'There is still a stigma attached to mental ill health and addiction, and all of us here and beyond still have a lot to learn about how we combat that stigma and treat the condition as a genuine illness and try to offer help to the individual as much as we possibly can.'

Labour's Tom Watson recalled him joking that they probably shared the same private investigator from the *News of the World*. He broke with Commons convention and spoke directly to the solemn figure of Donald, sitting in the gallery. 'Your father was a very great man; he stood up for what he believed in. He led a party of the centre-left with dignity and compassion. When you are older, you will know that your mum and dad believed in a cause greater than themselves and you will be proud.'

And Tim Farron, a contender for the Lib Dem leadership, did the same: 'Charles Kennedy was a very, very special man. Donald, you should be really proud of your daddy. I am proud of your daddy. I loved him to bits. I am proud to call him my friend. God rest you, Charlie.'

The University of Glasgow, where Mr Kennedy studied and served as rector, organised the memorial to pay tribute to their former student

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