NEWS

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Public satisfaction with emergency care rises

Gareth Iacobucci BMJ

The public's satisfaction with the NHS has changed little in the past 12 months after a record fall in 2011, show the latest results of the British social attitudes survey.

The health policy think tank the King's Fund said that the results, published this week, show that the record fall in satisfaction recorded in 2011 was not "a blip."

The annual survey, which tracks the British public's changing attitudes towards social, economic, political, and moral issues, shows that in 2012 just under two thirds (61%) of respondents were satisfied with the NHS. This is up slightly from the 58% satisfaction rate in 2011 but still some way below the 70% reported in 2010.

The steep fall in public satisfaction in 2011 coincided with the start of an unprecedented NHS spending squeeze and controversy over the government's proposals to change the healthcare system in England. But the King's Fund, which sponsored the health section of the survey for the second year, said that satisfaction may struggle to return to earlier levels in the face of ongoing pressure on the health service.

The survey showed an increase in the public's satisfaction with NHS emergency services, from 54% to 59%. Satisfaction with outpatient services (64%) and inpatient services (52%) showed no significant change from last year, while satisfaction with GP services (74%) and dentists (56%) was also unchanged.

In a departure from previous surveys, satisfaction with the NHS did not differ with respondents' political affiliation. The results showed a 64% satisfaction rate among Conservative and Labour supporters and 63% among Liberal Democrats. These results represented a slight decrease in satisfaction among Conservatives and Liberal Democrats from the previous year but a seven percentage point increase in satisfaction among Labour supporters.

Commenting on the results, John Appleby, chief economist at the King's Fund, said, "The British social attitudes survey has provided an important barometer of how the public views the NHS since 1983. With no real change in satisfaction with the NHS in 2012, this suggests that the record fall in 2011 was not a blip and that the ground lost may take some time to recover."

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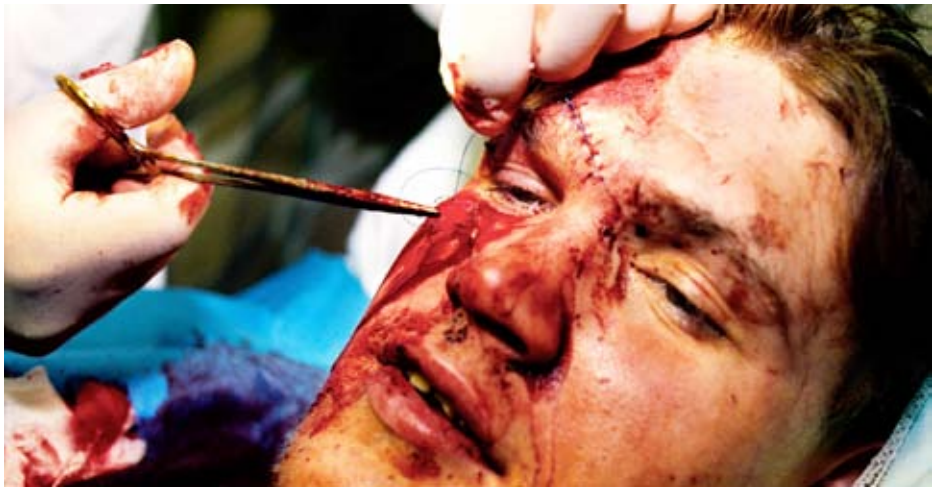

JON CHALLICOM/ALAMY

Satisfaction with the NHS is still below 2010 levels, but approval of emergency care has increased

Doctors' leaders urge government to amend commissioning regulations

Clare Dyer BMJ

Doctors' and nurses' leaders are urging the government to amend controversial regulations on commissioning NHS health services in England amid fears that they could require competitive tendering for most services.

The BMA and the Royal College of Nursing called on the government on 28 March to take urgent action to clarify the uncertainty, just days before the new "section 75" rules came into force on 1 April, amid the biggest shake-up of the NHS for a generation.

John Ashton, president elect of the UK Faculty of Public Health, and 33 other senior public health specialists have written to Stephen Dorrell, chairman of the health select committee, expressing concern that the NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 were coming into force "with inadequate consultation and confusion over their legal impact."

Department of Health officials have already redrafted the regulations once after pressure from GPs, royal colleges, and opposition politicians. But legal opinions obtained by the campaigning group 38 Degrees say that the regulations would still oblige the new clinical commissioning groups to put every service out to tender unless there was only a single capable provider available to provide the service.

The group says that the rules conflict with assurances given by the health minister Simon Burns that it would be for commissioners to decide which services to put out to tender.

The health department issued an eight page reply to the legal opinions from the healthcare law expert David Lock QC and the competition lawyer Ligia Osepciu, denying that the regulations would have the effect the lawyers assert.

In its response the department said, "The purpose of the regulations is simply to transfer to the new NHS commissioners the procurement requirements that currently apply to primary care trusts and to provide for Monitor—a sector specific regulator with expertise in healthcare—to enforce the rules rather than action through the courts."

The rules for awarding contracts will be identical to the requirements of existing procurement law, the department said.

Lock told the *BMJ*, "This response appears to duck the main problem with the regulations. Commissioners presently work under guidance, not rules. From 1 April they will work under rules, from which there is no escape."

Cite this as: *BMJ* 2013;346:f2091

Commissioners need clearer expectations and longer funding rounds

Zosia Kmietowicz BMJ

Commissioners of healthcare should be given budgets for more than a year so that they do not need to renew contracts with providers annually, the health regulator for England has said. This would give them greater financial stability and planning ability, it said.

The recommendation on how the NHS Commissioning Board should promote commissioning was included in a review by the regulator, Monitor, of what constitutes a "fair playing field" for providers of NHS healthcare.[1]

The review was commissioned last May in response to the Health and Social Care Act 2012, which places a legal requirement on the government that health providers should not be discriminated against on the basis of their ownership structure.

A discussion paper published by Monitor in January found evidence that "strongly suggested" that a number of issues were distorting the "playing field."[2] Most of these related to commissioning and tendering, with many healthcare providers complaining that there were too few opportunities to bid to run services.

To tackle this Monitor said that the NHS Commissioning Board needed to set "clear expectations" on how commissioners procured services, including emphasising the importance of commissioners considering all available options for improving services, especially when a current provider was underperforming. The board should also provide commissioners with better evidence of risks, costs, and benefits of different approaches to procurement; case histories; and tools to help them identify the best solutions.

The board should also speed up the development of standardised currencies (descriptions of what is being purchased for a given price) and provide better data on providers' costs, to give commissioners greater leverage to bundle or unbundle contracts so that they could be sure they were getting the best providers for a service, said Monitor.

It also recommended that the Department of Health should evaluate the effectiveness of the commissioning system in April 2014.

In its response to the recommendations the government said that it has asked Monitor to set up a "high level group" to review progress in creating a fairer playing field in the interests of patients. This will include looking at the recommendations further and then deciding what policy changes should be made.

Cite this as: *BMJ* 2013;346:f2041

Cross specialty training would improve academic psychiatry

Zosia Kmietowicz BMJ

Training of psychiatrists needs to be more flexible to encourage doctors to take up the specialty and pursue a career in academia, a report has said.

Simon Wessely and Nick Craddock want to see broader training to widen skills

Without a fresh approach to training, the advances being made in science were less likely to be translated into developments in diagnosis and management, because doctors were not choosing to teach future generation of psychiatrists, said Nick Craddock, professor of psychiatry at Cardiff University's department of psychological medicine and neurology.

He was speaking at the launch of the report from the Academy of Medical Sciences, *Strengthening Academic Psychiatry in the UK*.[1]

The number of posts in academic psychiatry in the United Kingdom has fallen by 27% since 2000. And although mental ill health accounts for some 15% of the disease burden, spending on mental health research makes up just 5% of the total UK health research budget.

Part of the problem was that psychiatry was not "projected sufficiently well enough," said Simon Wessely, vice dean in academic psychiatry at the Institute of Psychiatry in London.

Much UK academic activity was funded by the NHS, and, with demands for efficiency savings, managers saw academia as an area that they could cut without attracting unfavourable headlines, he said.

Training places in psychiatry also continued to be undersubscribed. In 2011 only 83% of the 478 first year training posts in psychiatry in England were filled, rising only slightly to 85% in 2012.

Trainees often wrongly believed that nothing could be done for psychiatric patients, said Wessely. And stigmatisation of patients with psychiatric problems meant that they were seen as difficult and challenging, he added.

One of the report's recommendations is to remove "unhelpful and constraining boundaries between psychiatry and related specialties" by developing integrated training programmes. This would allow psychiatrists in training to undertake modules in neurology, paediatrics, immunology, and other related disciplines and bring these skills to patients and other doctors if they chose to take up teaching posts.

Craddock said, "It is a fantastic time in the science of the brain. We have a fabulous opportunity to bring together a lot of disciplines to understand psychiatric illness, develop diagnosis and management, and take forward these skills to deliver better care and train doctors to deliver better care."

He added that the current system of specialty training was delivered with the short term requirements of the NHS in mind. This was different from the situation in the United States, where doctors' training was run by universities with a greater focus on the individual doctor's training needs.

The report also calls for improving research capacity in academic psychiatric and ensuring that trainees in the specialty can carry out doctoral research in optimal settings. At the moment many trainees may do their clinical training at some distance from their research base—a situation that the Academic Faculty of the Royal College of Psychiatry has described as "deeply concerning."

Cite this as: *BMJ* 2013;346:f2080

Hospitals plant trees to mark NHS sustainability day

Ingrid Torjesen LONDON

Several NHS organisations planted trees on 28 March to promote NHS sustainability day. The aim of the day, launched in 2012, is to encourage organisations to take action to combat climate change and to raise awareness of sustainability in the health service.

The Royal London Hospital was one of 25 sites in England to plant trees. Pictured (left to right) are Sarah Dandy, NHS forest coordinator at the Centre for Sustainable Healthcare, Oxford; Georgie Delaney, from the Great Outdoor Company, which sponsored some of the tree planting; and Fiona Daly, environmental manager at Barts and the London NHS Trust.

The tree planting is part of the NHS forest initiative, coordinated by the Centre for Sustainable Healthcare, which plans to make NHS estates greener by planting one tree for every NHS employee—1.3 million trees.

Cite this as: *BMJ* 2013;346:f2110

Roger Boyle: "A senior surgeon was away on holiday, another surgeon was suspended, and that left the service [at Leeds] being offered by two relatively junior locum surgeons."

AXEL HESS/ALAMY

Controversy rages over paediatric heart surgery in Leeds

Clare Dyer BMJ

Children's heart surgery at Leeds General Infirmary was suspended last week on the day after campaigners won a High Court ruling quashing a decision to close the unit as part of a plan to concentrate services in fewer, larger, and more specialised units.

Surgery at the Leeds unit was put on hold pending an internal review, after the NHS's medical director, Bruce Keogh, visited Leeds Teaching Hospitals NHS Trust on Thursday 28 March, along with representatives of the Care Quality Commission. He acknowledged that the timing of his intervention looked suspicious, coming only the day after Leeds campaigners won a High Court ruling that the "Safe and Sustainable" review would have to redo part of its consultation process.[1]

But he told BBC Radio 4's *Today* news programme that he could not refrain from taking action just because the timing was embarrassing. He had been telephoned on Tuesday by two "highly respectable, temperate" surgeons from outside Leeds, one alleging that the unit was refusing to refer complex cases elsewhere and the other raising concerns about staffing levels.

These were followed by a phone call on Wednesday from an "extremely agitated senior cardiologist" who had a preliminary report of mortality data showing that the Leeds figures for 2010-11 and 2011-12 were "considerably higher than any other unit in the country," he added.

Keogh's intervention sparked a war of words in the media. A local MP called for his resignation, and John Gibbs, chairman of the paediatric cardiac clinical audit, which supplied the mortality data, was quoted as saying that he was "furious" that the figures had been used, because they were in the very early stages.

The next day Roger Boyle, director of the National Institute of Clinical Outcomes Research at University College London, defended Keogh on the *BBC Breakfast* television programme, saying that he had advised suspension of surgery at the unit himself. "I was aware last weekend of other concerns being raised about Leeds—concerns raised by distinguished surgeons who don't work in the area, concerns raised by families through the Children's Heart Federation that they weren't being given the opportunity to be transferred to other units when they'd requested that," he said.

"And I was also aware that a senior surgeon was away on holiday, another surgeon was suspended, and that left the service being offered by two relatively junior locum surgeons."

Cite this as: *BMJ* 2013;346:f2098

Indian Supreme Court rejects Novartis's appeal on drug patent

Sophie Arie LONDON

India's highest court has rejected efforts by the Swiss drug firm Novartis to patent its anticancer drug imatinib mesilate (marketed as Glivec) in a ruling in favour of India's generic drug industry.

After a seven year legal battle the Supreme Court ruled that the drug was only an updated version of an existing one and as such was not innovative enough to merit a patent.

The ruling is seen as a crucial victory for manufacturers of generic drugs in the battle for India's large and fast growing market. It means that international drug companies cannot acquire fresh patents on existing drugs in India by making minor changes to them, a process known as "evergreening."

The aid charity Médecins Sans Frontières hailed the decision as "a huge relief for millions of patients and doctors in developing countries who depend on affordable medicines from India."

Glivec, which is used to treat chronic myeloid leukaemia and other cancers, costs about $2600 (£1710) a month. The generic equivalent is currently available in India for just $175.

But Novartis said that the Supreme Court's ruling "discourages future innovation" by denying the firm the fair return on its product that it needs to carry out research into the drugs of the future.

Ranjit Shahani, vice chairman and managing director of Novartis India, told reporters in Mumbai that the company would be cautious about investing in India from now on.

India, which produces most of the generic drugs used in developing countries, only introduced patent laws in 2005 under pressure from the World Trade Organization, and it awards patents only for drugs created since 1995.

Novartis had patented a version of imatinib in 1993. But the firm argued that it was entitled to a patent on the newer version of the drug because it took several years' more work to develop the original patented compound into a pill.

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MPs said it was unclear who would be in charge during a health emergency, such as the 2009 swine flu outbreak

ADRIAN BROOKS/REX

New public health system is marred by confusion, say MPs

Adrian O'Dowd LONDON

The new public health system which started this month in England is flawed in several ways, including confused accountability and questions over who would be in charge during health emergencies, MPs have warned.

Overall, MPs on the parliamentary Communities and Local Government Committee have welcomed the return of responsibility for improving the general health and wellbeing of local people from the NHS to local government, but they say that many issues still have to be resolved.

In its new report the committee said that it had concerns over the complex accountability mechanisms of the new system.[1]

One example was the lack of clarity over who would be in charge in the event of a local or national health emergency such as an outbreak of a disease. Under the new structures, various bodies will organise and be involved in public health, including local health and wellbeing boards, clinical commissioning groups, and the national bodies Public Health England and the NHS Commissioning Board.

"Many [organisations] are still unclear who will be in charge locally in the event of a health emergency, and the government needs to set out the lines of responsibility between these organisations and confirm that Public Health England will have sufficient staff in its local teams to deal with contingencies," says the report.

The committee's chairman, Clive Betts, the Labour MP for Sheffield South East, said, "Without clarity there is only confusion, and a health emergency is no time for muddle. The government must set out unambiguously the lines of responsibility, and it must do so now as a matter of urgency. These arrangements need to be clear and in place on day one, 1 April. Anything else is unacceptable."

Arrangements for screening and immunisation services will be the responsibility of the NHS Commissioning Board, but the MPs said the arrangements lacked a local dimension.

They argued that it was a good idea to devolve these services, along with public health services for children up to 5 years old and childhood immunisation services, to public health staff within local government under directors of public health.

It was unclear, said the MPs, as to whom clinical commissioning groups (CCGs) would be held accountable, and they rejected the government's arguments for not allowing local authority councillors to sit on them. Local areas should be allowed to decide who was able to sit on a CCG board.

How the new health and wellbeing boards were to be held accountable, and to whom, was another area of confusion, said the MPs, so it was important that the government clarified this.

Betts said, "Under the . . . system, considerable power is to be invested in a range of new bodies. With such power must come accountability.

"With these changes it is clear that there is a shift of power and money from Whitehall to local government. I welcome that. But the new arrangements are complex, and responsibilities are shared across several bodies. The result is that lines of local accountability are fragmented and blurred."

Other problems had become apparent, said the committee, in the new arrangements, such as the fact that, under the current funding formula, areas that performed well would have their funding cut.

Cite this as: *BMJ* 2013;346:f2027

Healthwatch must be properly resourced for its job, charities say

Caroline White LONDON

An independent "consumer watchdog" for adults' and children's health and social care services has now been set up in each of the 152 local authorities across England, in time for the 1 April deadline, the Local Government Association has told the *BMJ*.

Under the terms of the Health and Social Care Act 2012 it is a statutory requirement from 1 April for local authorities to commission, fund, and performance manage the local Healthwatch bodies. They are the fourth reconfiguration in 12 years of bodies intended to represent the interests of local patients and the public.

Most will be run by voluntary groups and charities, but seven are being run with the private sector as social enterprises. All will be supported nationally by Healthwatch England.

The government has chipped in with £40m over two years, an amount that is based on the previous spend of the outgoing Local Involvement Networks (LINKs). But the money has not been ringfenced.

It is feared that cash strapped local authorities may not invest enough to give Healthwatch the clout to influence and challenge the provision of local services, as intended.

As well as acting as an information hub for local communities, their remit will include raising concerns about the quality of local services nationally—a role that has assumed more importance in the wake of the inquiry into the failings at Mid Staffordshire NHS Foundation Trust.[1]

"The issue of how well resourced they are is one of overriding concern," said Tom Gentry, a policy adviser for the charity Age UK. "Some [local authorities] might grasp the nettle and put in the budget, but others will provide the bare minimum and box tick."

Cite this as: *BMJ* 2013;346:f2020

CORRECTION

Issue 16 March, pp 4-6: "More than a third of GPs on commissioning groups have conflicts of interest, *BMJ* investigation shows"

This recent *BMJ* investigation by Gareth Iacobucci (*BMJ* 2013;346:f1569) stated that five GPs on the governing body of NHS Blackpool Clinical Commissioning Group (CCG) listed interests in Virgin Care. This statement was based on a list of registered interests provided by NHS Blackpool CCG via a Freedom of Information request. The *BMJ* would like to clarify that the local practices in question have now resigned from Assura Blackpool, the limited liability partnership jointly owned by Virgin Care and local practices.