

this week

ANTIDEPRESSANTS page 87 • NHS FUNDING page 89



Angry GPs hit back at May's threats

The prime minister, Theresa May, has met with an angry backlash from GPs after she threatened to withhold funding from general practices that did not offer their patients longer opening hours.

GPs accused the government of scapegoating the profession and ignoring the true causes of the pressures across the NHS in England, after practices were warned through a series of inflammatory headlines that funding could be withheld unless they could prove they were informing patients of additional appointment slots.

May's intervention occurred as the government came under pressure to tackle the crisis in hospital emergency departments. But GPs said the prime minister was wilfully ignoring the underlying factors of underfunding, soaring demand, and staff shortages. GP leaders also cited an evaluation of the existing pilot schemes for seven day GP access, which found no reduction in emergency department admissions and low demand for GP appointments on Sundays.

May also came under fire from her own party, with Sarah Wollaston, the Tory chair of the House of Commons Health Committee and former GP, saying the public and NHS staff "deserved better than scapegoating, smoke, and mirrors." Reacting to No 10's

announcement, Wollaston tweeted, "Pretty dismal stuff for government to scapegoat GPs for very serious NHS pressures. It is beyond belief anyone would think that attacking an overstretched and demoralised primary care would serve any purpose."

The prime minister's intervention also sparked outrage among grassroots GPs. Peter Weeks, chairman of Cumbria Local Medical Committee, wrote to all GP members on 16 January to thank them and to condemn the government. He wrote, "Threats and bullying on such a scale as happened in the media this weekend are sickening. To blame the overburdened, struggling, understaffed workforce for the failings of a system is shameful."

Chaand Nagpaul, chair of the BMA's General Practitioners Committee, said GPs already delivered care 24 hours a day, seven days a week in their surgeries and via out-of-hours arrangements and that many offered evening and weekend appointments despite a lack of demand. He added, "The government should take responsibility for a crisis of its own making and outline an emergency plan to get to grips with the underlying cause—the chronic under-resourcing of the NHS and social care."

Gareth Iacobucci, *The BMJ*

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Theresa May was criticised by MP Sarah Wollaston for "attacking an overstretched and demoralised primary care [sector]"

LATEST ONLINE

- Still too little transparency among guideline writers
- A fifth of healthcare spending is wasted, says OECD report
- Cleveland Clinic to re-evaluate its Wellness Institute after director questions vaccines



MEDICINE

Research news

Campaign doubles meningitis vaccination

A University of Nottingham campaign asking new students if they had been vaccinated against meningitis and offering free vaccination more than doubled meningococcal ACWY vaccine coverage. Only 10% of first year students (n=1000) who registered with the university's health service in September had been vaccinated, and just over half accepted the free vaccination, increasing coverage to 20%. (doi: 10.1136/bmj.j1111)

Aspirin use for tension headache is questioned

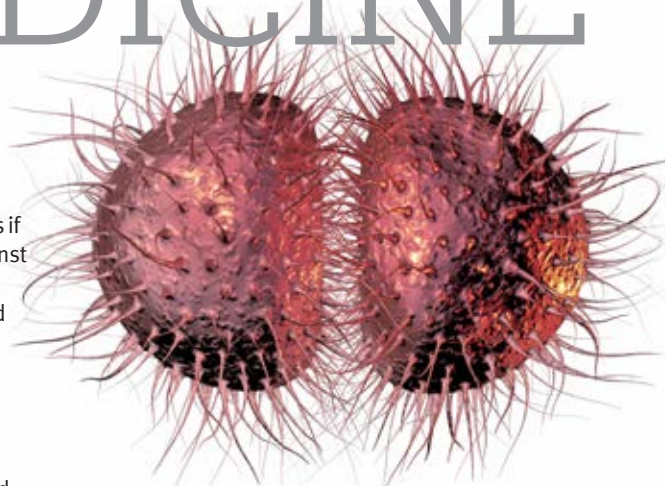
A Cochrane review of the effectiveness of aspirin in adults with frequent tension-type headache found no randomised studies listing data on people free of pain two hours after taking the analgesic, which is the preferred outcome for assessing headache treatments. However, use of rescue medicine was lower with aspirin, as only 10% of people who took 100mg aspirin needed additional painkillers, compared with 20% who took placebo. (doi: 10.1136/bmj.j1111)

Cosmetic surgery

Voluntary certification system is launched



The Royal College of Surgeons introduced the first voluntary certification system to allow patients to identify surgeons with recognised training in specific cosmetic procedures. Surgeons must provide evidence of training, professional and clinical skills, knowledge, and experience. They must also attend an accredited master class on professional



Nottingham University doubled meningococcal ACWY vaccinations

and ethical aspects of cosmetic surgery practice.

Disease prevalence

Women's midlife eating disorders more prevalent

Eating disorders, presumed to affect primarily adolescents and young adults, also occur frequently in women in midlife, a study in BMC Medicine showed. It included 1000 UK women in their 40s and 50s and found that 10% reported having had an eating disorder in the past months. Under 5% of women who reported having had an eating disorder had sought help or received treatment. (doi: 10.1136/bmj.j1111)

No evidence in a third of previous asthma diagnoses

A third of adults who had asthma diagnosed in the previous five years showed no evidence of current asthma, a study published in JAMA found. Current asthma was ruled out in 33% of participants using home peak flow and symptom monitoring, spirometry, and serial bronchial challenge tests. The authors said this could be due to spontaneous remission or initial misdiagnosis. They recommended that doctors review patients to see if treatment can be stepped down or stopped. (doi: 10.1136/bmj.j1111)

Cite this as: *BMJ* ; ;

A&E PATIENTS 153 564

patients who presented to A&E in London in 2014 were not registered with a GP, found a survey by BBC Radio London

SIXTY SECONDS ON... ANTI DEPRESSANTS



THIS IS THE MOST DEPRESSING WEEK OF THE YEAR

Cheer up. The claim that the third Monday in January is the year's most depressing day (Blue Monday) was a clever wheeze dreamed up in 2005 to sell winter holidays.

BUT IT'S DARK, COLD AND GLOOMY. IF THAT ISN'T A DOWNER, WHAT IS?

Evidence from Canada indicates that major depressive episodes are commoner in the winter: 25% higher in January than August, for example. But suicide peaks in the spring.

NEXT YOU'LL TELL ME DEPRESSION ISN'T INCREASING

It is, but slowly in the UK, says Glyn Lewis, professor of psychiatric epidemiology at University College London. What has increased is antidepressant prescribing, but even that has flattened off in recent years.

ARE TOO MANY DRUGS PRESCRIBED?

Impossible to say, Lewis told a briefing at the Science Media Centre in London. It could be too few, as only a third of people with the severest symptoms are taking the drugs. He's running a research project, funded by the National Institute for Health Research, designed to help GPs decide when and to whom to prescribe, but the results aren't in yet.

HOW WELL DO THE PILLS WORK?

Reasonably well. Andrea Cipriani, associate professor of psychiatry at Oxford University, told the briefing that trial data showed 50% of patients responded. But 25% respond to a placebo, so that's not quite as impressive as it seems. There's room for improvement.

AND IS THAT COMING?

No time soon, says Guy Goodwin, professor of psychiatry at Oxford. He said there's little enthusiasm among drug companies to look for new antidepressants that would have

to compete with cheap generics. The industry can't make money on these drugs, he said.

THAT IS DEPRESSING

If science came up with a new understanding of depression, Goodwin said, things might change. But as it stands, I'd be surprised if we get any more drugs in the next decade.

Nigel Hawkes, London

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Trolley waits in England rise sixfold in six years

A huge quantity of data are published by the NHS in England covering all parts of the service. The keenest attention is always paid to hospital performance, where data on key measures are published monthly. The latest release, covering the period to the end of November 2016, appeared on 12 January.

EMERGENCY DEPARTMENT WAITS

The NHS Constitution sets the standard that 95% of patients attending hospital accident and emergency departments should be seen, admitted, or discharged within four hours. In July 2016 NHS Improvement changed the rules slightly, saying that for 2016-17 the aim of hospital trusts should be to improve so that by quarter 4 they could once more meet the standard.

In November 2016 88.4% of patients waited less than four hours, down from 91.3% in November 2015. The lowest figure shown in any recent month was 87.3%, in March 2016. So the standard is not being met, and there is little sign of the improving trend that is sought.

TROLLEY WAITS

The NHS counts the number of people waiting to be admitted to hospital after four hours, so called trolley waits. In November 2016 these numbered 52 769, much more than

the 34 170 in November 2015. The trend is steeply upward: in November 2010 only 7179 had to wait more than four hours, giving a rise of 635% in six years.

Tim Gardner, senior policy fellow at the Health Foundation, said that, in light of these figures, "The NHS has begun this winter in a worse position than at any time over the last five years."

DELAYED DISCHARGE

One reason why hospitals cannot find beds for new patients is that they have been unable to discharge patients who are ready to leave. The data are gathered as a snapshot of a single day: the last Thursday of each month. On Thursday 24 November 2016 there were 6825 patients whose discharge was delayed, up from 5573 on the equivalent day in November 2015.

The chief reasons are patients waiting for places in nursing or residential homes or who await a care package in their own home, which together accounted for almost 1000 extra delayed discharges over the number in 2015 and representing 75% of the year on year change. The other 25% were mostly accounted for by patients waiting for completion of assessments by hospital staff.

Margaret Wilcox, vice president of the Association of Directors



of Adult Social Services, said that the delays were "a matter of enormous concern that reflects the crisis facing adult social care."

WAITS FOR ELECTIVE OPERATIONS

Here, the target is that more than 92% of patients should wait no more than 18 weeks from referral to treatment. In November 2016 90.5% of patients were seen within this period. In November 2015 the equivalent figure was 92.4%, but that was the last month in which the target was met.

Among those hitting the 92% target were ophthalmology, cardiology, and dermatology while orthopaedics, ENT, and urology were among those missing it.

WAITING TIMES FOR CANCER PATIENTS

Seven of the eight cancer standards continue to be met, the exception being the target that 85% of patients with cancer should wait no longer than two months between an urgent referral by the GP and the treatment beginning. This has been achieved in only one month since May 2014. In November 2016 82.3% of patients were treated within the target, roughly the same proportion as every month for the past two years.

Nigel Hawkes, London

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NHS crisis: where should any new money be spent?

Until 2014 the NHS in England was given emergency funding to cover extra demand on services over winter. However, seen as a "panic measure" that came too late in the year to be used properly, it was scrapped in 2014. Instead NHS England has for the past three years built the £400m annual payment into local allocations up front. Despite the NHS experiencing its worst crisis in 15 years, Theresa May has been steadfast in her refusal to pump extra money into the system. Simon Stevens, NHS England's chief executive, has said that he would put any extra funding available into social care.

The BMJ asked doctors, managers, and council representatives where they would put money from a winter pressure cash injection.

JOE HARRISON, CHIEF EXECUTIVE, MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

"Invest any additional monies in community, mental health, and social care services, which as a statement coming from an acute care trust chief executive might seem slightly odd. However, specific targeted money to reduce the numbers of patients taking up beds who could be looked after elsewhere is, in my view, critical to taking the pressure off the acute service."

RICHARD VAUTREY, DEPUTY CHAIR, BMA'S GENERAL PRACTITIONERS COMMITTEE

"What's happening now is due to the fact that we haven't invested properly in primary care, social care, and community nursing services. One of the things GPs want to do is to avoid admitting patients to hospital, but the only way they can do that is if they know there is going to be a rapid response from experienced nurses, working often in collaboration with social care colleagues."

SIMON ABRAMS, CHAIR, URGENT HEALTH UK, AND GP IN LIVERPOOL

"As chair of a federation of social enterprise out-of-hours GP providers, I believe that additional funding invested in those services would reap benefits across the system. For example, more elderly patients with complex comorbidities can be effectively assessed and sustained in the community when experienced GPs with knowledge of the local health economy are available."

Zosia Kmiotowicz, Gareth Iacobucci, Abi Rimmer, *The BMJ*

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"The NHS has begun this winter in a worse position than at any time over the past five years" Tim Gardner, Health Foundation

PETER HOMA, CHIEF EXECUTIVE, NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST



“By improving the flow of patients through and out of our hospitals”

“Additional investment in social care and the community would have the most significant impact on our health and social care system, by improving the flow of patients through and out of our hospitals. This would include additional community beds, access to more social care support packages, and providers employing more care workers and social workers, with clear career opportunities to attract and retain these vital staff.”

JANE DACRE, PRESIDENT, ROYAL COLLEGE OF PHYSICIANS



“Our hospitals are over-full, with too few qualified staff”

“As we outlined in our letter to the prime minister last week, our NHS is underfunded, underdoctored, and overstretched. Our hospitals are over-full, with too few qualified staff, and our primary, community, and social care and public health services are struggling or failing to cope. The immediate actions that would help the most are the reinvigoration of social care services and urgent capital investment in infrastructure. With investment, we can reverse the reductions in social care services and start to address the increasing demands on the health service.”

CLIFFORD MANN, EMERGENCY CARE DOCTOR AND CLINICAL LEAD FOR A&E IMPROVEMENT, NHS ENGLAND



“Often at weekends we are unable to discharge patients”

“I would recommend the money be allocated to the interface between health and social care. We really need to make seven day discharge a reality to even out the pressures on acute and elective services. To do this we need to employ more occupational therapists and to commission transport services. Often at weekends we are unable to discharge patients because there is no one to take them home and assess them. This creates avoidable admissions and longer lengths of stay.”

HELEN STOKES-LAMPARD, CHAIR, ROYAL COLLEGE OF GENERAL PRACTITIONERS



“There is nowhere to discharge patients”

“Probably the single biggest thing we could do to help move patients through the hospital would be to open up a step-down centre with care beds for patients who no longer need acute care services but who are not yet fit for discharge into the community. [We need to provide] something for people so that they are safe and cared for when they are discharged from hospital. Community hospitals are so out of fashion, but they played a vital role in rehabilitating people.”

PETER HOLDEN, GP, DERBYSHIRE, AND URGENT CARE ADVISER



“The truth is that practices need more money”

“Practices should be given the money per patient head count to deploy as they see fit, with no bureaucracy attached, because otherwise it does not get used for frontline services. Unfortunately we can't just magic workforce out of the ground. The truth is that practices need more money. It would not be out of order for GPs to pay themselves more for all the extra work they are doing. When hospital doctors do extra hours they get paid for it. GPs are working hard, and there is nothing wrong with spending any extra money on ourselves.”

IZZI SECCOMBE, CHAIR, LOCAL GOVERNMENT ASSOCIATION'S COMMUNITY WELLBEING BOARD



“The funding gap facing social care could be at least £2.6bn by 2020”

“Genuinely new government money is now the only way to protect the services caring for our elderly and disabled people and to ensure they can enjoy dignified, healthy, and independent lives. How any new funding for social care would be spent should be a local decision.

“We have estimated that the funding gap facing social care could be at least £2.6bn by 2020. We need half of this right now to stabilise the provider market and half by 2019-20 to deal with the pressures from an ageing population, inflation, and the national living wage.”

NHS leaders are failing to “speak truth unto power”

Promises to deliver the impossible are endemic in NHS management culture, **David Lock** says

This article started as an expression of serious frustration at the way the NHS is run and at some senior managers’ willingness to become complicit in something near to dishonesty. Then, against the backdrop of a winter crisis in the NHS, the mood changed, and it became prescient. We saw Simon Stevens start to admit that the NHS was underfunded by political decision makers and was, in effect, being asked to deliver the impossible.

Everyone at the front line of care knows that the NHS is running on empty. The more perceptive know that more money for the NHS will not by itself improve services for patients. But—and this is perhaps the unpopular “but”—NHS senior managers ought to accept their share of the responsibility for the present crisis, because they have colluded in pretending the NHS can deliver the impossible. Does anyone believe that, at least until recent days, NHS



managers had “spoken truth unto power” about the limits of NHS productivity?

STPs more fiction than reality

The sustainability and transformation plans are the latest idea where NHS managers have been asked to promise to deliver the impossible. In response, the NHS has signed up plans that are more fiction than reality. Privately, NHS senior managers know that the STPs are not deliverable, for a series of interlocking reasons.

First, they know the NHS doesn’t have effective procedures for change management. Every small change has to be negotiated and agreed in detail with all stakeholders before it can get the green light. Thus every clinical commissioning group, every truculent local authority, and every NHS trust can veto any change. That stops controversial plans happening for years.

Second, politicians can block change. Time after time, local managers are

over-ruled by senior NHS staff to avoid political embarrassment.

Third, even if changes could be agreed locally, the capital needed to deliver effective change is not available. Managing change is expensive; new buildings cost money and must be built before old ones are sold, and thus “double running” is inevitable. Capital money to fund STPs is spent plugging existing deficits. The iron rule of public service seems to have been lost: that you can spend the same money only once.

Failed process

So why is the NHS repeating a failed planning process? Because it has been told to. Many in the NHS will reluctantly admit that its management culture has been close to dishonest. NHS England or NHS Improvement has told commissioners and providers what plans must deliver. Once targets have been set, it has not been acceptable to say that a plan to

FIVE THINGS HEALTHCARE CAN LEARN FROM ENGINEERING



John Clarkson, a fellow of the Royal Academy of Engineering, has been working with healthcare organisations to investigate a systems approach to healthcare redesign. On 24 January he’ll be speaking at the Health Foundation’s annual conference in London. Here are some of the things he’s learnt during his work on health system design

1 Iteration before implementation

“Engineers tend to iterate before they do something. That’s not a comment on what is right or wrong but more an observation. In clinical healthcare you quite often get iteration after you do something. Often it’s the scale of things you do—typically incremental change, meaning that you try something, see if it works, try something again. As engineers we wouldn’t build a bridge to see if it works.”

2 Design is exploratory

“Design is about options. Can we really understand what the problem is, based on the need? And to solve that problem, can we think of a range of solutions to help us find the one that really works best? Design is about exploring the need and then exploring solutions to the problem.”

3 Proactive risk management

“In engineering risk management is proactive. That’s how engineers see things. A lot of risk management in healthcare is: ‘Something’s happened—why?’ As engineers we’re saying, ‘What could possibly go wrong?’ To engineers, risk management is a proactive and forward looking process.”



Simon Stevens, NHS England's chief executive, is one of few managers to admit all shall not be well

create financial balance or to deliver 95% performance on emergency department targets “cannot be done.” It has been equally unacceptable to say, “It cannot be done without substantial capital investment, money for double running, and political will to deliver a series of unpopular changes.”

NHS officials have come under intense pressure to produce plans that confidently predict the undeliverable, and most have bowed to that pressure. “Optimistic” (but in reality fictional) plans get signed off, and the “system” confidently tells ministers that all shall be well, all shall be well, and all manner of thing shall be well. But now even Stevens is admitting that all shall not be well without substantial new investment in health and social care or substantial lowering of standards. Until recently, no one in the NHS has been allowed to state the obvious.

The NHS in England is in the mess it is today because of promises that it will do more than the funding can deliver. That is primarily the fault of politicians, but NHS management culture must bear its part of the blame. A change in the NHS management culture is long overdue.

Stevens came close to telling MPs on the Public Accounts Committee that, within present resources, there is a limit to what the NHS can achieve. Does this intervention mark a change of culture such that NHS officials have the courage to speak truth unto power?

David Lock QC, chairman, Innovation Birmingham, and member, BMA Medical Ethics Committee
DLock@landmarkchambers.co.uk

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Everyone at the front line of care knows that the NHS is running on empty

4 Thinking changes practice

“If you change the way people think they will change what they do, within existing boundaries. People may have their own improvement processes, and if we can change the way they think, it may change what they do within their own process. There’s a sense of ownership. However, for others a new process may have more value.”

5 Excellence isn’t common

“Something that was said to us so many times was, ‘There’s nothing new here; it’s not rocket science; it’s common sense.’ My response would be that common sense is not common. There are islands of excellence in healthcare, and a good few of them. But what we are talking about here is not common, and if it had been, and if it was, we wouldn’t still be trying to understand the role of a systems approach in healthcare.”

Winter pressure leaves surgeons short of training

Surgeons are missing vital training opportunities because of the current winter crisis in the NHS, trainees have said.

Adam Williams, president of the Association of Surgeons in Training, told *BMJ* Careers that trainees were often being called out of operating theatres to assist on the wards.

“Ultimately, the emphasis has shifted from combining training with high quality service delivery, to maintaining basic service delivery at all costs,” Williams said. “There are myriad examples of trainees having to leave teaching opportunities both in theatre or clinic to assist on the wards.”

Williams said his association and the British Orthopaedic Trainees Association had been concerned about the situation for a number of months, and that it had worsened recently.

“In surgery we often find that, while the pressures at the ‘front door’ and on the wards remain suffocating, the theatres remain eerily quiet because we have too few ward and intensive care unit beds. This is detrimental to the patients, and detrimental to trainee experience,” he said.

Williams said that there was a “very real fear” that trainee surgeons could fail their

annual review of competence progression and will have not worked on enough cases to achieve their certificate of completion of training.

“We cannot learn when the cases never reach the operating theatre because there are no safe postoperative beds in which to care for the patients,” he said.

“We cannot learn when the cases are being performed, but we are pulled away to help in the emergency department.”

A Royal College of Surgeons spokeswoman said that, although patients should remain the focus during the current crisis, “we shouldn’t overlook the impact NHS pressures are having on staff and in particular on doctors in training.

“Surgeons in training tell us that they are being asked to do work for emergency departments and under-staffed wards in addition to their own roles,” she said. “As a result they are losing out on the theatre time.”

She added, “Definitive action must be taken to free up hospital beds. We must not risk patient safety and irreversibly damaging the training of our future NHS workforce.”

Abi Rimmer, *BMJ* Careers

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AGENCIA FOTOGRAFICZNA CAROJALAMY





THE BIG PICTURE

Making a song and dance about trachoma

Children take part in an eye care club at a school in Kedida Gamela, Ethiopia, after a performance to launch an antibiotic administration scheme to prevent trachoma. Two in every five children have trachoma in this rural region; without treatment they may lose their sight and face destitution.

The BMJ's Christmas appeal for 2016-17 is for the eye care charity Orbis, which aims to eradicate preventable blindness worldwide. Nurses trained by Orbis educate teachers, who run school clubs to teach children about eye care and early intervention, including hygiene, the importance of seeking immediate care, and treatment options.

Trachoma is the world's leading cause of infectious, preventable blindness, and 75 million people are at risk in Ethiopia alone. But it could be eradicated through surgery, antibiotics, access to clean water, and better hygiene and sanitation.

Last year Orbis's supporters helped fund 65 558 operations, including 24 177 on children, and 2.13 million screenings. The charity has also trained 1414 doctors. *The BMJ's* readers have given more than £14 400, and there's still time to donate.

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Post this to: Orbis, Freepost RTLK-HLXZ-LKHU, 124-128 City Road, London EC1V 2NJ

(no stamp needed but using one saves sight)

- I'd like to donate £239, which could provide surgical training on the flying eye hospital for two doctors
- I'd like to donate £150, which could pay for six intraocular lenses for cataract surgery
- I'd like to donate £84, which could cover the cost of glasses to improve the vision of eight children
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Geoff Oliver Bugbee/Orbis

Investigating avoidable patient deaths

Families must come first, not corporate damage limitation

The Care Quality Commission's (CQC) review of the way in which NHS trusts review and investigate the deaths of patients in England makes for sobering reading.¹ It emphasises that learning from deaths needs to be given much greater priority to avoid missing opportunities to improve care.¹

The review also found that no trust had good practice across all aspects of identifying, reviewing, and investigating deaths and ensuring that learning is implemented, but that some trusts showed promising practice at individual steps.¹ This comes as a welcome affirmation for patients and families, and as a validation of how they have, all too often, described their unsatisfactory experiences of interactions with healthcare services and professionals in the aftermath of adverse events.²

Patients for patient safety

The experiences of the World Health Organization's Patients for Patient Safety cohort, representative of over 50 countries, are testament to the reality that what the CQC reports is a global problem that needs to be tackled as such.

Of note is the comment by Ireland's former chief medical officer Tony Holohan after meeting with parents during a review of perinatal deaths: "There are many examples in which patients have not always been dealt with honestly. Even worse, in some circumstances patients have been deliberately misled or have been lied to."

Although that is difficult to hear, patients and families respect the integrity behind the willingness of this leader to nail his colours to the mast and acknowledge the reality. Such acknowledgment is the necessary first step to learning and improvement.

Litigation is not a first port of call for patients and families—inappropriate responses force them to embark on that route as they search for truth.



JOHN COLE/SPL

The CQC's findings and recommendations emphasise the need for greater, more robust, respectful, and compassionate engagement with patients and families. Jim Conway, when he was senior vice president of the US Institute for Healthcare Improvement, described the push-pull dynamic of that engagement process as "Making the status quo uncomfortable while making the future attractive." Therein lies the challenge to leaders, as we ask them to embrace patients as meaningful partners in designing and achieving that attractive future.

In 2004, WHO bit that particular bullet with the launch of the World Alliance for Patient Safety.³ The global medical community moved to viewing patients and families as a valuable untapped resource and also recognised the potential of the patient experience as a learning tool. Consequently, the alliance designated patient and consumer involvement (patients for patient safety) as one of its action areas.

Patients want healthcare organisations to proactively engage patients in their care; capture in every way possible the lessons from the experiences of patients; and embed patient and family into every aspect of their activities. By doing so, organisations recognise that the patient is the only person who is present throughout the full continuum of care, is a wonderful repository of information, and, crucially, has the greatest vested interest in the outcome.

Litigation is not a first port of call for patients and families—inappropriate responses force them to embark on that route as they search for truth

To achieve these goals, we ask the healthcare system and individual practitioners to conduct the business of healthcare in a culture of safety, openness, transparency, and true professionalism.

Disclosure is not about accepting or apportioning blame. It is about integrity, professionalism, and, above all, trust.

Open disclosure

When patients call for care that is delivered in accordance with the BMA's motto: "With head, with heart, with hand"—when they seek reporting and learning, transparency, accountability and open disclosure, patient engagement, and involvement as a human right—those exhortations are most often grounded in their experience of avoidable harm or death through medical error.

They need and deserve to know the circumstances surrounding these events and feel entitled to reassurance that lessons will be learnt and disseminated in the hope of preventing recurrence.

The enemy of learning is to focus on corporate damage limitation. Successful review systems (as shown by the CQC review¹) effectively identify the risk (the five whys used in root cause analysis) and point the way to mitigating that risk, while achieving improvement and allowing the patient experience to be a catalyst for change.

Margaret Murphy, external lead adviser, WHO Patients for Patient Safety Programme, Geneva
margaretmurphyireland@gmail.com

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Political crisis in the NHS

The government should heed the warning signs and embark on fundamental reform

The real NHS crisis is political not humanitarian. Politicians of all parties have failed to provide sufficient funding for health and social care, with predictable and sometimes distressing consequences.

Hospitals are struggling to meet rising demands from a growing and ageing population, and most are failing to hit the four hour waiting time target in emergency departments. Patients are being cared for on trolleys in corridors, and this is compromising patient safety—illustrated by reports of the death of patients in Worcester.¹

The challenges facing hospitals result from failure to invest sufficiently in services in the community to provide care in people's homes and help them remain independent. General practices, district nursing, and social care have all been affected, resulting in patients attending hospital because of the lack of appropriate alternatives.

Eye of the storm

Social care is in the eye of the storm, with the number of people receiving publicly funded care falling by more than 400 000 since 2009-10.² Neglect of social care means that a growing number of people receiving hospital care cannot be discharged when their treatment has finished because of lack of community support.

Many emergency departments are seriously overcrowded, with patients waiting for a bed to become available.³ The spectre of ambulances waiting to discharge patients to emergency departments is the inevitable and unwelcome consequence.

None of this should be a surprise. Winter pressures are a familiar feature, and the result of cuts in social care funding and constraints in NHS funding have been clear for some time. The NHS is approaching breaking point, and urgent action is needed to avoid a bad situation becoming much worse.^{4 5}

The failure of successive governments to act on these reports is an indictment of a political system that too often avoids dealing with complex social issues

This is as much a test of politicians as it is of the NHS, which has worked tirelessly to ensure patients are cared for safely after months of winter planning. Will the government heed the warning signs and bow to pressure for a fundamental review of health and social care funding? Or will it resort to sticking plaster solutions without tackling the underlying causes across the whole of the NHS and social care?

The answers to these questions matter because they affect millions of people at a time of need and anxiety. Older people, people with disabilities, and patients with acute medical conditions are experiencing longer waits for care,⁶ and publicly funded social care is provided only to those in greatest need and with limited resources. The impact on staff, who have become the shock absorbers in an underfunded health and care system, is increasingly a concern.⁷

The government's response to the prison crisis suggests that a sticking plaster is the most likely outcome. This could involve finding extra cash for hospitals to signify to the public that ministers are taking the problems of the NHS seriously. It might also entail a boost to social care to support patients to be discharged from hospitals and free up beds for those waiting in emergency departments.

While any support is to be welcomed, it is unlikely to make an immediate impact because of the time it takes to use new funding to

improve services. What is far more important is to recognise that current pressures are an "acute on chronic" manifestation of a system that needs fundamental reform. Not only is the level of funding inadequate, but how care is provided has failed to keep up with changing demography.

A succession of expert reports has reviewed what needs to be done, including the Royal Commission on long term care in 1999,⁸ Derek Wanless's review in 2006,⁹ the Dilnot Commission in 2011,¹⁰ and the Barker Commission in 2014.¹¹ All have concluded that root and branch changes are needed to the funding and delivery of care, and yet none has been implemented.

Integration, integration, integration

Fundamental reform should include increased public funding, integration of NHS and social care budgets, and closer alignment of entitlements to health and social care, as proposed by the Barker Commission.

The failure of successive governments of all stripes to act on these reports is an indictment of a political system that too often avoids dealing with complex social issues.

That is why the NHS crisis is political. It is the result of short term thinking geared around election cycles and an unwillingness to deal with long term challenges that are not amenable to incremental changes. A preference for adversarial point scoring rather than crossparty consensus is an insurmountable obstacle to the kind of political leadership that is desperately needed.

We should of course be concerned about the huge pressures on the NHS and social care and their effect on patients and service users, but we should be terrified by a political process that seems incapable of tackling the root causes of these pressures.

Chris Ham, chief executive, King's Fund, London, UK
C.Ham@kingsfund.org.uk



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A profession in step with today's NHS?

In the latest of his series, **Gareth Iacobucci** examines what is required of a modern medical workforce and the barriers it faces to change

This series has explored how societal changes and shifts in government policy have affected the NHS. Clinicians have inevitably seen their role change, too.

As well as mastering clinical expertise, today's clinicians are under pressure to show that their performance matches that of their peers, that they are aware of patient safety, and willing to blow the whistle. They are also now expected to develop skills to improve services, move away from tribalism and embrace collaborative working, and adapt to new technologies.

In the past, these were seen as desirable rather than essential attributes, but modern care standards demand more from clinicians.

How the UK measures up

The Organisation for Economic Cooperation and Development (OECD) concludes that, while access to care is good in the UK, the quality of care remains variable and continues to lag behind that in many other developed countries.

Although cancer survival rates have improved over the past 10 years in line with the OECD average, the UK is still in the bottom third of countries in five year relative survival for colorectal, breast, and cervical cancers.

In acute care, UK survival rates after hospital admission for cardiac arrest or stroke improved faster than the OECD average in the five years leading up to 2013, but they are still worse than in many OECD countries.

The UK compares favourably to other developed countries in avoiding hospital admissions for people with diabetes, but less so for other chronic diseases such as asthma and chronic obstructive pulmonary disease.

Cultural barriers and professional tribalism must be overcome before progress can be made



Unwarranted variation

Tackling unwarranted variation in clinical practice would help improve some of these headline figures and provide more cost effective care. The pioneering US researcher Jack Wennberg first coined the term “unwarranted variation” to describe differences in healthcare “that cannot be explained by variation in patient illness or patient preferences.”

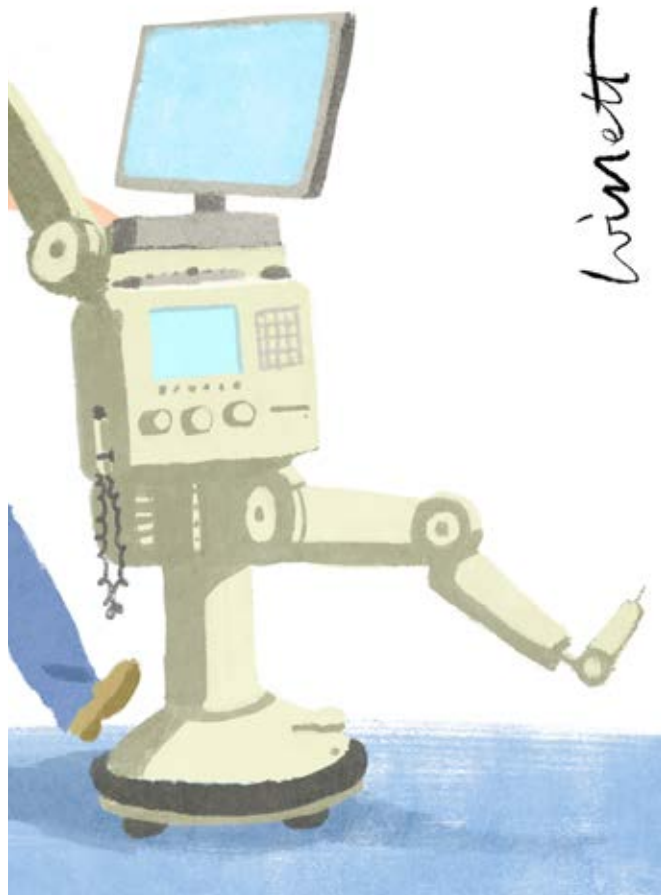
In 2011, the King's Fund think tank concluded that variations in the quality of general practice and hospital treatment “remain persistent and widespread,” with some of these unwarranted. In 2016, a report by Patrick Carter, who was commissioned by the government to investigate how to improve quality and efficiency in the NHS, challenged clinicians to play their part in tackling huge variations in areas such as the cost of inpatient treatment, infection rates, procurement, and use of clinical staff.

After reviewing NHS hospital activity across the whole country, Carter identified £5bn of potential

savings broken down by clinical specialty. The biggest savings were in general medicine (£381 000), obstetrics and gynaecology (£362 000), and trauma and orthopaedics (£286 000).

Carter's recommendations are now being taken forward by Tim Briggs, the NHS's national clinical director for quality, and Tim Evans, national clinical director for productivity. As part of this, 137 non-specialist NHS acute hospital trusts have received detailed plans showing how and where they can improve patient care and become more efficient. The work of the Carter report is supplemented by the NHS Right Care programme and Atlas of Variation, which use data from sources including national clinical audits to map variations in outcome, quality, cost, and activity for a range of clinical areas.

The third and most recent edition of the atlas, published in 2015, identified unwarranted variation in several areas, including speed of cancer diagnosis; number



The UK is still in the bottom third of OECD countries for five year relative survival for colorectal, breast, and cervical cancers

In 2014, the NHS went further by making mortality rates for individual consultant surgeons public across 10 other surgical disciplines—including vascular, bariatric, colorectal, and neurosurgery—as part of a push to improve outcomes.

The drive was spearheaded by cardiac surgeon and medical director of NHS England, Bruce Keogh, who said greater transparency would improve quality of care.

Although some surgeons opposed the extension to other surgical areas on the same grounds as cardiac surgeons, the NHS is committed, publishing mortality rates for around 5000 surgeons on its NHS Choices website.

Patient safety

Robert Francis's 2013 public inquiry into the scandal at Mid Staffordshire NHS Foundation Trust called for patient safety to be embedded at the heart of the NHS as part of a fundamental cultural change.

Francis's report identified serious failings among hospital managers and nursing staff that contributed to poor care at the trust, but he also concluded that many clinicians "kept their heads down" and "did not pursue management with any vigour with concerns they may have had."

The report was the catalyst for a greater focus on patient safety led by the health secretary, Jeremy Hunt. He introduced a new inspection regime and the publication of service ratings from the Care Quality Commission (CQC).

But the NHS still has some way to go before it embodies Hunt's stated aim of becoming "the world's largest learning organisation." In its most recent annual state of care report, the CQC said that patient safety remained the weakest of the five domains measured across all health and social care facilities in England. It said this is

often influenced by the quality of leadership within an organisation.

The biggest safety concerns are identified in acute hospitals, of which 10% are currently rated "inadequate." The CQC identifies lack of staffing as a key reason for trusts scoring poorly, alongside other factors such as variation in support for reporting and learning from incidents, incomplete safety audits, poor data sharing, and a lack of essential training for staff.

Mental health services also score poorly on safety, with 9% rated "inadequate." The CQC says this is often because of problems with the physical environment.

The CQC says follow-up inspections show trusts making improvements in staffing and recruitment, staff training, and coordination of services but there remains room for improvement.

Quality improvement

Although there is some evidence that policy drivers such as Ara Darzi's *Next Stage Review* have had a positive effect on quality in the NHS, an evidence review from the Health Foundation think tank said the reluctance of some healthcare professionals to engage in quality improvement remains "a long-standing, multi-factorial and international problem."

"Deep seated problems remain and manifest in the interest shown in [doctors'] attendance at events relating to quality and safety and their lack of willingness to undertake, for example, near miss reporting," the foundation said.

It added that this reluctance was partly down to a belief that quality improvement initiatives "are driven by management to reduce costs or that they will be ineffective or increase workload for little gain."

Skills shortfall

A lack of knowledge and skills among clinicians to improve services has been identified as an important barrier to improving quality in healthcare. But royal

of patients admitted quickly to specialist units after a stroke; level of antibiotic prescribing from general practitioners; and number of patients with diabetes receiving the full range of annual checks. Differences in the way guidelines for referral are applied, and in the detection and identification of disease, contribute to these variations, it says.

Publication of performance data

The NHS has led the way as the first healthcare system in the world to make individual surgeons' death rates publicly available. Cardiac surgeons were the first to publish their mortality rates in 2005, and subsequent research suggested that the policy was associated with fewer deaths in cardiac surgery.

A 2010 study concluded that fears that the policy would cause surgeons to avoid high risk patients do not seem to have been realised. "While disclosure may have a small effect on individual reputations, the surgical profession as a whole has embraced disclosure," it said.

Carter identified £5bn of potential savings broken down by clinical specialty. The biggest savings were in general medicine £381000

colleges and some NHS trusts have taken steps to remedy this.

The Royal College of Physicians launched the “learning to make a difference” initiative to try to make improvement part of the core skill set of medical trainees. And NHS trusts that have embedded quality training widely across staff have shown improvements. For example, since launching its quality improvement strategy in 2008, Salford Royal Foundation Trust has achieved a 100% reduction in meticillin resistant *Staphylococcus aureus* infections, an 83% reduction in *Clostridium difficile* infections, a 48% reduction in inpatient cardiac arrests, and a 79% drop in grade 2 pressure ulcers. It has also consistently ranked in the best 10% nationally on risk adjusted mortality.

Elsewhere, mental and community healthcare provider East London NHS Foundation Trust has seen a 23% reduction in violence across all inpatient wards and sustained improvement across 28 quality improvement projects since it launched its programme in 2014.

The independent *Shape of Training* review published in 2013 was commissioned because professional medical training in the UK was out of step with the current

needs of patients and the NHS. The report made wide recommendations for change, including training more generalist doctors and shortening the length of training in some specialties to four to six years.

Some organisations representing medical trainees, including some royal colleges, warned that the recommendations risked deskilling doctors, and damaging recruitment if poorly implemented. Although the royal colleges are considering changes to their curriculums to reflect the review’s recommendations, organisational resistance remains.

Such resistance can also make interdisciplinary partnership difficult within the NHS. In a 2015 study of NHS acute hospitals and integrated care, the King’s Fund observed examples of providers “adopting protectionist behaviours and retreating into their organisational silos when competition for funding became most extreme.”

NHS England wants to change this by removing the historical boundaries and silos that exist in the NHS. Its proposed new models of integrated health and care underpin an ambition to create a more joined up system and reduce the number of fragmented and chaotic processes of care delivered to patients.

New structures may help to reduce bureaucracy and gaps in communication between different professionals and departments. But once again, cultural barriers and the “professional tribalism and turf wars” that exist within some healthcare organisations must be overcome before progress can be made.

A common theme across case studies of integrated care cited by the King’s Fund was that sufficient time needed to be invested in getting influential senior clinicians “on side” with projects.

“Advocates of integration... needed to be highly tactical in communicating the case for change... for example, by arguing for an integrated service on the basis of improving outcomes and quality,” it said.



Working better, not harder

COMMENTARY

Jennifer Dixon

Asking your medical friends how life is at work always provokes gripes, but the pressure the NHS is now under has hiked these to fever pitch.

There is ample reason. The NHS is under unprecedented budget constraint, staff are working flat out, under enormous pressure to protect patients and at great cost to themselves. Social care is at “tipping point.” The strain is uniquely challenging, and should not be underestimated.

Many working in clinical care feel fury: bitter blame is heaped on politicians, managers, commissioners, regulators; and there is a loud chorus for more money and staff, less bureaucracy and interference, and more support. If I want to be very unpopular, I ask medical colleagues if any are involved in management, and then bolt for the bunker because this often induces apoplexy.

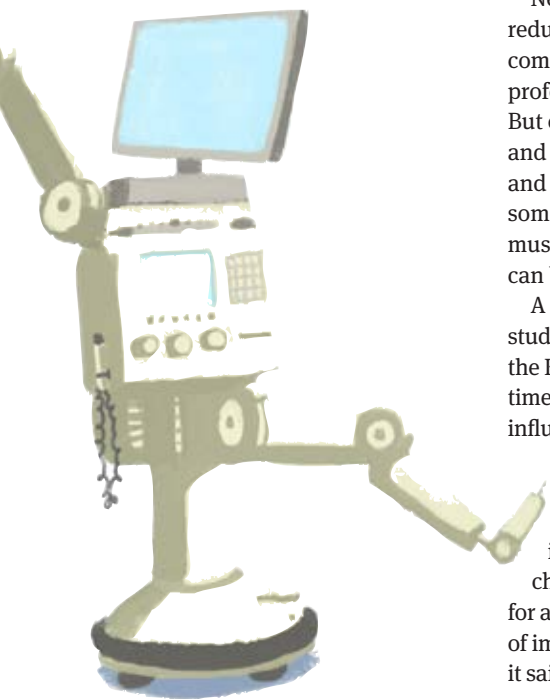
But under the current headlines of acute pressures lies some inconvenient evidence: waste, variation, poor communication and coordination of care, and related unsafe practices—not just in management, commissioning, or Whitehall, but at the clinical front line.

The majority of the issues faced are people problems, not technology problems

Technology

New developments in information technology are consistently pinpointed as a key mechanism for transforming and improving delivery of healthcare, but like most health systems around the world, the NHS has been slow to embrace them.

The government wants this to change, but needs clinicians to be more willing to embrace technology. In a 2012 Canadian study, researchers found that key factors influencing clinicians’ adoption of technologies included technical design, performance, and support; implementation processes and workflows; coordination; and performance related financial incentives.



Iacobucci's article references ample recent testimony—for example, the Carter review, Right Care, the NHS Atlas of Variation, and inspection reports by the Care Quality Commission. The public notices too: a recent poll showed that 51% of the public think the NHS wastes money, especially people using the NHS most often.

Underlying this are familiar themes: many clinicians “kept their heads down” and “did not pursue management with any vigour with concerns they may have had”; many clinicians are reluctant to improve the quality of services because initiatives were driven by management.

When I was a medical student and junior doctor I received no training on well established quality improvement techniques to improve services, management, leadership, how the NHS works, or how to work collaboratively in teams with patients and across provider boundaries. That territory was just not staked out as being a legitimate pursuit for doctors or part of medicine.

There has been substantial progress since then (albeit from a very low base) in these areas and others, with far more opportunities for doctors. But progress isn't fast enough. We move slowly and are being overtaken by events, despite the impressive commitment and skill of staff, heroic efforts, some excellent leadership, and the enthusiasm of young doctors particularly.

In the UK, barriers to adoption have included fears that technology may compromise patient confidentiality and undermine patient safety. There are also cultural and behavioural barriers, including concerns about the possible erosion of clinicians' autonomy.

“The majority of the issues faced along the journey of transformation are people problems, not technology problems,” said a recent report from the Nuffield Trust think tank. “This means that organisations need to invest at least as much into the programmes of organisational change and transformation as they do in the technology itself.”

Technology evangelists are keen to highlight evidence of the



It is easy to point the finger at others—the shortage of funds and staff is now acute. But the engine room of the NHS is the clinical front line, where management and teamwork need to be at their best—not an optional chore best avoided or done reluctantly. Managing clinical services better does not necessarily mean a formal management post or working harder. It can mean skilling up in a few basic areas such as quality improvement techniques and applying them in everyday work. Even now, there are plenty of good examples with impressive results which motivate, and people and other resources to help. Institutional support is critical to make faster progress, but not any progress.

We've had decades of debate about why doctors in the NHS are not filling more management positions, especially as chief executives. Management is a skill that may not

potential benefits the NHS could derive from new technologies, be it portable blood pressure monitors, integrated electronic medical records, or computer based interventions to improve self management. But the evidence is far from clear cut. For example, a UK evaluation of the cost effectiveness of telehealth for patients with long term conditions found no difference in quality adjusted life years (QALY) compared with patients receiving usual care only and higher total costs.

If the government can produce a convincing, evidence based plan to harness the most effective elements of digital technology, as

A recent poll showed that **51%** of the public think the NHS wastes money, especially people using the NHS most often

come easily to those selected into medical training, and reluctance to be exposed—especially in today's harsh climate—is understandable. But those with aptitude can and should be trained.

One example worth considering is the Mayo Clinic, which identifies doctors with excellent clinical skills and management ability, provides well thought through training on the job with support, and continuously selects them over years into more senior positions based on proved ability.

It does not take a high cost health system to do this—in the NHS there will be developing examples, but not enough. It can be done; we aren't taking it seriously enough. Working better does not necessarily mean working harder.

Jennifer Dixon, chief executive, Health Foundation, London

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well as fulfilling promises around investment, interoperability, and information governance clinicians may have fewer reasons to be wary of change.

With the NHS frontline under such pressure, finding time, breathing space, and the right culture to develop skills in the areas outlined here will not always be straightforward for clinicians. But if the potential benefits in even some these areas could be unlocked, the NHS could reap substantial benefit from a highly motivated clinically led workforce delivering improved health outcomes to the population.

Gareth Iacobucci, senior reporter, *The BMJ* giacobucci@bmj.com

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Niall Dickson, 63, has just stepped down as chief executive and registrar of the General Medical Council after nearly seven years and taken up a new role as chief executive of the NHS Confederation, the representative organisation for NHS providers. A Scot educated at Edinburgh University, he taught for two years before working for Age Concern England and then moving into journalism. He was editor of the *Nursing Times* in the 1980s and then social affairs editor on BBC television and radio news, where he worked for 16 years from 1988. Yet another career switch saw him take over as chief executive of the King's Fund, where he commissioned the seminal review of social care funding by Derek Wanless before joining the GMC from January 2010. Under his leadership the regulator has introduced revalidation, taken on responsibility for postgraduate medical education, and brought in fundamental reforms to its fitness to practise procedures, including an autonomous adjudication service.

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Niall Dickson From BBC to GMC to NHS

What was your earliest ambition?

To be a bus driver. It was to be unrealised, though not without trying—I failed the selection process. The nearest I got was being a bus conductor in Fife.

Who has been your biggest inspiration?

The English master at school, who made me believe in myself and got me interested in printing, communication, and journalism.

What was the worst mistake in your career?

Getting the victim's and murderer's names the wrong way round in a TV report on the *Six O'Clock News*. It required an on-air apology the next day.

What was your best career move?

May I cite two? If so, joining the BBC and the GMC. The BBC gave me the most amazing opportunities to talk to some of the iconic figures of our age, from Princess Diana, through prime ministers, to great achievers such as Dame Cicely Saunders.

Who has been the best and the worst health secretary in your lifetime?

The worst was probably John Moore. A decent man doomed by circumstances, high expectations, and his own attempts to impress Margaret Thatcher by trying to be super-radical. The best? I genuinely don't have one I'd single out. Suffice it to say that Patricia Hewitt was, in my view, underestimated and had a poor hand of cards.

Who is the person you would most like to thank, and why?

Sir Richard Doll, for saving more lives than just about any other doctor in the 20th century and for helping me to give up smoking.

If you were given £1m what would you spend it on?

A more secure future.

Where are or were you happiest?

In Scotland, with family and on the golf course.

What single unheralded change has made the most difference in your field?

The internet.

What poem, song, or passage of prose would you like at your funeral?

"Abide with Me."

What is your guiltiest pleasure?

Not confessing to my guilty pleasures.

What television programmes do you like?

House of Cards.

What personal ambition do you still have?

To be a wonderful grandfather.

What is your pet hate?

Chatterboxes in train carriages when I'm trying to work—like now!

What would be on the menu for your last supper?

A sleeping pill.

Do you have any regrets about becoming a health expert?

No—Edith Piaf had it right. The reality is that you spend your career painting a floor, you find yourself in a corner surrounded by wet paint, and then they describe you as an expert.

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