Law to force trusts to charge migrants

The UK government is to press ahead with plans to make it a legal requirement for NHS hospitals to charge foreign visitors and migrants upfront and in full for any non-urgent care received, as part of its crackdown on so called health tourism.

New regulations, to be laid out in parliament “in due course,” will kick start the government’s bid to recover £500m a year in costs of treatment of patients from countries inside and outside the European Economic Area by the end of 2017-18, a target that the National Audit Office has said ministers will struggle to meet.

The plans, initially set to be implemented on 1 April 2017, seemed to have been shelved in the wake of the Brexit referendum and were not included in the Queen’s speech last month. But the Department of Health for England has now confirmed that it is pressing ahead.

The government first launched a programme in 2014 to tackle concerns that the NHS was “overly generous” to visitors from overseas. This included a new requirement for migrants and foreign visitors from outside the EEA to pay an additional 50% on the cost of treatment they received on the NHS and a policy to pay NHS hospitals 25% extra on the top of the cost of every procedure carried out on visitors from the EEA who have a European health insurance card (EHIC).

But progress has been slow. In a written answer disclosed in the House of Commons last week the government said that the UK had recovered £56m from EEA countries in 2015-16, leaving it some way short of the £200m a year that it had targeted as part of the overall £500m.

Although the new legislation will not affect migrants and visitors from other EEA countries who have their treatment costs covered through the EHIC, this may change in the future, depending on the terms of the UK’s exit from the European Union.

Phillippa Hentsch, head of analysis at NHS Providers, said it was important that the measures did not compromise care or unduly burden trusts. “Rather than continue setting targets, we should prioritise helping trusts to learn from each other about what works,” she added.

A spokesperson for the Department of Health for England said, “The government remains committed to ensuring overseas visitors and migrants not eligible for NHS funded care make a fair contribution.”

The government remains committed to recovering £500m a year from treating patients not eligible for NHS care.

Cite this as: BMJ 2017;358:j3371
Mental health
Extra funding is not getting through, say leaders
The government’s commitment to improving mental health services in England is being undermined by a failure to channel funding to the front line, NHS leaders warned. NHS Providers, which represents NHS trusts, surveyed nearly two thirds of England’s mental health trusts and found that rapidly rising demand, workforce shortages, and a failure of funding to get through to the front line were causing mental health services to deteriorate.

STPs
Councils feel shut out of talks to reshape services
Less than a quarter of local politicians are confident that plans to reshape local health and care services will succeed, the Local Government Association found. The association, which represents local authorities in England and Wales, also found that most councillors did not feel involved in shaping, commenting on, or approving the NHS’s 44 sustainability and transformation partnerships (STPs), and they criticised the “unilateral top-down approach” of the NHS in some areas.

Brexit
Brexit poses risk to NHS finances, say trust leaders
More than half of NHS trusts (54%) warned that the UK’s impending exit from the EU poses a medium or high risk to their organisation’s financial health. Some 90% of NHS trust finance directors surveyed by the Healthcare Financial Management Association identified staff recruitment and retention as a key risk area. Most directors (68%) identified agency costs as a risk to their financial plans and a main area where they plan to make savings.

UK ministers call for EU cooperation on drugs
The health secretary, Jeremy Hunt, and the business secretary, Greg Clark (right), said that the UK will continue to cooperate with the EU on medicine testing after Brexit. In a letter to the Financial Times they outlined three principles for developing a post-Brexit drug regulatory system: that patients should not be disadvantaged, that innovators should be able to get their products to the UK market as quickly as possible, and that the UK should continue to have a leading role in promoting public health (see p 100).

Social care
Poor care in one in four adult social care services
An overview of 33 000 regulatory inspections of more than 20 000 locations from 2014 to May 2017 by the Care Quality Commission found that 23% of services were rated as requiring improvement on safety, while 2% were rated inadequate on this indicator. Some 75% were rated good for safety, but less than 0.5% were rated outstanding. Examples of unsafe practice include poor medicine management and inadequate staffing.

Research news
Sugar in pregnancy is linked to allergy
Pregnant women who consume high levels of free sugars during pregnancy are more likely to have a child with allergy or allergic asthma, a study in the European Respiratory Journal suggested. Researchers from Queen Mary University of London used data from the ALSPAC study, which looks at the offspring of predominantly white women living in Avon, UK, who were due to give birth from April 1991 to December 1992.

GP leaders ballot profession on mass list closure
GPs’ representatives in England have begun balloting general practices on the potential mass closure of patient lists in response to the ongoing crisis facing the profession.

The move comes after local medical committees, which represent GPs locally, passed a motion at their annual conference in May (left). This demanded that the BMA’s General Practitioners Committee ballot GPs on whether they would be willing to collectively close their lists in response to the huge pressures facing general practice and the inadequate response of NHS England’s rescue package.

In a letter sent to GPs on 10 July, Richard Vautrey, acting chair of the General Practitioners Committee, urged GPs to take part in the ballot by Thursday 10 August. He advised practices that collective list closures “would constitute industrial action” and have “significant implications” for GPs as independent contractors.

“GPC England needs a clear understanding of the views of all GP practices on this issue, and I would therefore urge you to ensure that your practice takes part in the ballot,” he said.

A briefing document accompanying the letter explains that practices may cease the registration of new patients in two ways: by temporarily suspending new patient registrations, or by applying to the service commissioner for formal list closure. The guidance also explains that closing practice lists can be agreed only as a partnership.

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2017;358:j3374

Doctors are warned over image sharing
Doctors who share clinical information over file sharing apps and websites may be in breach of ethical obligations, the Medical Defence Union warned. It issued the warning after several members reported increasingly using apps to share clinical information. As well as gaining patients’ consent before sharing images, doctors should ensure that images are taken on a dedicated clinical camera, quickly downloaded and then deleted from the camera, and transmitted and stored securely, the union advised.

15 July 2017 | the bmj
Sexual health

Drug resistant gonorrhoea is rising, warns WHO

Data from 77 countries showed that gonorrhoea is increasingly resistant to treatment, as high income countries in particular report infections that are impossible to treat. WHO’s global Gonococcal Antimicrobial Surveillance Programme published new data in *PloS Medicine* showing that 66% of countries reported the emergence of strains resistant to the current last resort treatment—extended spectrum cephalosporins in the form of oral cefixime or injectable ceftriaxone.

Organ donation

Scotland plans move to opt-out system

Scotland will introduce legislation aimed at increasing organ donation by moving to a “soft opt-out” system that will allow organs to be used in transplants without express permission. This is a reversal of the current situation, where people have to opt in by joining the donor card scheme. It follows a public consultation in which more than 80% of respondents supported the change.

Immunisation

Hepatitis B added to infant vaccination schedule

The hepatitis B vaccine is being introduced for newborns from the autumn, making the UK one of the last countries in Europe to introduce a universal hepatitis B vaccination programme for infants. All babies born on or after 1 August 2017 will be eligible for Infanrix hexa, which also protects against diphtheria, tetanus, pertussis, poliomyelitis, and disease caused by *Haemophilus influenzae* type b. The vaccine can also be used in children who have missed some primary immunisations.

Inquiry

Inquiry to look into blood transfusion deaths

The government is to hold a full inquiry into how thousands of people with haemophilia were infected with hepatitis C and HIV after blood transfusions in the 1970s and 1980s, before blood donors were routinely screened for the infections, Downing Street said. The health secretary, Jeremy Hunt, said that the inquiry would look into the deaths of 2400 people “to establish the causes of this appalling injustice,” a spokesman said.

Infectious disease

Dengue fever kills hundreds in Sri Lanka

A deadly outbreak of dengue fever in Sri Lanka has killed at least 225 people and infected more than 76 000. Speaking to Sri Lanka’s *Daily News*, the country’s health minister, Rajitha Senaratne, warned that the death toll could increase as flood waters recede further. WHO has sent 450 troops to help combat the spread of the disease by aiding with rubbish collection and other sanitation issues.

Cite this as: *BMJ* 2017;358:j3356

ABORTION

One in four women who had an abortion in 2016 were using hormonal or long acting contraception at the time.

In total, 51% who requested abortions were using contraception, including non-hormonal methods such as condoms and diaphragms

*[British Pregnancy Advisory Service]*

WHAT’S TO BE DONE?

The Foundation for Responsible Robotics wants society to start looking at these issues and decide whether any regulation is needed, such as banning childlike robots, and whether such robots should be available on prescription.

Ingrid Torjesen, London

Cite this as: *BMJ* 2017;358:j3353

WHAT A YEAR TO SINK INTO ROBOTS

OH, DEAR. WHAT DEPTHS IS THE BMJ SINKING TO NOW?

Actually, this is an important medical issue. Robots specifically designed to satisfy the owner’s sexual desires are available to buy now. Some of them can even speak, and designers are working on including AI to make them better companions.

HOW EASY ARE THEY TO BUY?

Four companies are now marketing adult sex robots for between £3800 and £11 620.

BUT NO ONE REALLY WANTS A RELATIONSHIP WITH A ROBOT

Apparently they do. Last year 17% of 1002 adults questioned for the Nestle FutureFest survey said that they would be prepared to go on a date with a robot, and that increased to 26% for a robot that looked like a human.

Phil, a 58 year old man who lives on Jersey, bought a robot for sex and now pushes it around in a wheelchair. Another man actually left his wife and family for one.

SO THEY’RE JUST FOR LONELY GEEKS?

A report from the Foundation for Responsible Robotics says that we could see sex robots being used to satisfy the sexual needs of disabled and elderly people and as part of therapy for people with issues such as erectile dysfunction, premature ejaculation, and anxiety about sex.

SO, THERAPEUTIC?

To a point. Controversially, it has also been suggested that sex robots could be used to help prevent sex crimes such as violent assault, rape, and paedophilia, but most experts warn that this could increase the occurrence of these crimes, as well as the objectification of women. There’s already a childlike model, by Trottla, available in Japan; and the Roxxy model, by TrueCompanion, has different selectable personalities, one of which (“Frigid Farrah”) will resist sexual advances.

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SIXTY SECONDS ON... SEX WITH ROBOTS

Gonorrhoea resistant to all antibiotics is spreading

SO/space.tabTHEY’RE/space.tabJUST/space.tabFOR/space.tabLONELY/space.tabGEEKS?

BUT/space.tabNO/space.tabONE/space.tabREALLY/space.tabWANTS/space.tabA/space.tab 

WHAT/space.tabDEPTHS/space.tabIS/space.tabTHE/space.tabBMJ/space.tabOH/comma.tab/space.tabDEAR/period.tab/space.tabWHAT/space.tabDEPTHS/space.tabIS/space.tabWITH/ROBOTS

“MERZO”/comma.tab/space.tabIS/space.tabIT/space.tabNOW?/space.tab

ME/DAYS/OF/SECONDS

SEVEN/THIRTY/SECONDS

SEVENTY/SECONDS

SIXTY/SECONDS

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Cite this as: *BMJ* 2017;358:j3353
German doctors condemn internet TV series depicting teenage suicide

Two psychiatric societies and a paediatrics association in Germany have condemned a new internet television series about a 17 year old girl who dies by suicide, saying that the series could trigger so called copycat suicides among troubled young viewers.

In addition, Germany’s Professional Association of Paediatricians (BVKJ) has called for the “immediate cancellation” of the series. A member of the association’s board, the paediatric cardiologist Josef Kahl, said that “adolescents contemplating suicide will probably be influenced in that direction by the series.”

The 13 part series, called 13 Reasons Why, was produced in the US for Netflix and released around the world on 31 March. The title of the German language version of the series is Dead Girls Don’t Lie (Tote Mädchen lügen nicht). The series has been so popular that Netflix announced that a second 13 part series will be produced for release in 2018.

A character in the series, Hannah Baker, leaves behind audiotapes detailing the 13 reasons why she would eventually commit suicide. The series shows events leading up to her contemplating suicide, including bullying, rape, drunk driving, and so called “slut shaming.”

In the final episode Hannah’s suicide is enacted in graphic detail and shows her reclining in a water

Fall in deaths from heart failure questions need for ICDs

The risk of sudden death in patients with symptomatic heart failure has halved over the past 20 years, a large study has reported. The authors suggest that the decrease is paralleled by greater use of evidence based drugs, such as angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers, and they question the benefit of implantable cardioverter defibrillators (ICDs) in most patients.

The study analysed data from 40 195 patients with heart failure and reduced ejection fraction who were enrolled in any of 12 clinical trials from 1995 to 2014. The results, reported in the New England Journal of Medicine, showed that the rate of sudden death fell by 44% throughout this 20 year period (P=0.03).

Sudden death occurred in 2.4% of patients taking part in the earliest trials, but this decreased to just 1.0% in the most recent trial.

Current guidance recommends that patients receive drug treatment for three months before considering use of an ICD. However, the researchers said that this may be too short a period and that the ejection fraction may continue to increase six to 12 months after starting drug treatment.

John McMurray, of the British Heart Foundation Glasgow Cardiovascular Research Centre at the University of Glasgow and who led the research, concluded, “Our study suggests that new efforts are needed to better identify the high risk subgroup of patients who would benefit most from ICD implantation.”

Susan Mayor, London

Cite this as: BMJ 2017;358:j3309

SUDDEN DEATH occurred in 2.4% of patients taking part in the earliest trials, but this decreased to just 1.0% in the most recent trial.
A GP has been suspended for 12 months after an undercover reporter for the *Sun* newspaper secretly recorded him selling a medical certification for taxi drivers without conducting a medical examination.

Ashrafu Haque Mirza (inset right), 42, of south London, admitted to a Manchester hearing of the Medical Practitioners Tribunal Service that he had recorded a blood pressure reading and vision readings despite not performing the necessary tests during a two minute consultation.

Mirza also admitted signing a statement in the form attesting he had seen the patient’s full medical records, when in fact he had not. He admitted that he had been dishonest in doing so and in initially denying his wrongdoing to NHS England and the General Medical Council after the *Sun* published its story.

The statement said that therapists, social workers, and teachers have reported that adolescents with affective disorders who had watched the series were being harmed.

The series failed to adhere to well recognised “international guidelines” on reporting and depicting suicide, the statement said, because it showed a graphic enactment of the suicide, implied that suicide was a “logical consequence” of the girl’s suffering, and romanticised the suicide. The statement also said that the girl’s status among classmates was posthumously elevated, with her locker at the high school turned into a sort of shrine visited by students.

The series has also been criticised in other countries, prompting Netflix to strengthen its advisory warnings. The Canadian Mental Health Association and Australia’s National Youth Mental Health Foundation were among those that have issued critical statements on the series.

In the US the National Association of School Psychologists recommended “that vulnerable youth, especially those who have any degree of suicidal ideation,” avoid watching the series. “Its powerful storytelling may lead impressionable viewers to romanticize the choices made by the characters and/or develop revenge fantasies,” the association said.

A joint statement issued by the German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy and the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology said that “suicidal crises and even suicides” thought to be linked to the series have already been reported to the psychiatric societies.

The undercover reporter performed similar stings on two other London GPs. Mirza and one other were named by the paper, and video was released of the consultations. The third remains unidentified. The newspaper also found other agencies helping drivers to cheat on their topographical knowledge tests.

The newspaper’s coverage in October 2016 prompted a small demonstration in central London by drivers of licensed black cabs who said that Uber and minicab drivers were being certified when not competent or fit.

**Deregistration sought**

The coverage also drove Mirza to seek mentors as the GMC investigated him. One of those was Clare Gerada, a former chair of the Royal College of General Practitioners and medical director of the NHS Practitioner Health Programme. While two other senior doctors testified that Mirza had been fully frank with them about his dishonesty, Gerada’s “carefully phrased” answers indicated that he had not told her he had made up the readings entered in the driver’s medical declaration, said the tribunal’s chair, Melissa Coutino.

Counsel for the GMC urged the panel to strike off Mirza, referring to an incident in Glasgow where a medically unfit driver caused a crash, resulting in the deaths of six bystanders. At one point during the video the “patient” tells Mirza, “When I get tired, my vision gets a bit blurry.”

Mirza’s defence lawyer argued that he had been fasting, had had a busy bank holiday weekend, covering for an absent partner, and was tired and thus less than usually conscientious.

Coutino said: “The tribunal recognised that you have apologised for your actions and that you engaged with your five mentors, attended courses in order to discuss your misconduct, and have undertaken remediation by attending courses and providing a reflective statement.”

Erasure would be a “disproportionate” response to a two minute incident in an otherwise unblemished careers of two decades, she added. Mirza’s case will be reviewed shortly before his suspension ends in 12 months.

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**Adolescents contemplating suicide will probably be influenced in that direction by the series**

Filled bathtub and then slitting her wrists and arms lengthwise.

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The BMJ
Cite this as: BMJ 2017;358:j3367

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**GP is suspended for certifying taxi drivers without tests**

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The BMJ
Cite this as: BMJ 2017;358:j3362

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Black cab drivers protested in 2016 that minicab drivers were being certified when not competent

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Ned Stafford, Hamburg
Cite this as: BMJ 2017;358:j3367
Over half of anaesthetic trainees have had car crash or near miss

Over half (57%) of anaesthetic trainees have experienced a crash or near miss when driving home after a night shift, a survey conducted by the Association of Anaesthetists of Great Britain and Ireland has found.

The vast majority of respondents said they had felt too tired to drive home after a night shift.

Over half (57%) of anaesthetic trainees have experienced a crash or near miss when driving home after a night shift, a survey conducted by the Association of Anaesthetists of Great Britain and Ireland has found.

The study, published in Anaesthesia, outlined the findings of the survey, which received 2170 responses from UK anaesthetic trainees.

Most (84%) of the respondents said that they had felt too tired to drive home after a night shift, and 57% said that they had experienced a crash or near miss in doing so.

Respondents talked about falling asleep at the wheel and about being woken by rumble strips on the road, the paper said. “Adverse events were not only reported by motor vehicle users. There were also multiple reports of such events amongst walkers and cyclists,” it said.

The survey found that only a third (32%) of trainees were aware of the existence of rest facilities in hospitals where they could sleep after a night shift, and just 17% had ever used such a room to sleep. The reasons given by trainees for not using rest facilities included “just wanting to get home” or the unsuitability and lack of accessibility of facilities.

Laura McClelland, a coauthor of the study, said, “We want rest facilities made available to people not only while they’re working on their shift but also for an unlimited period between shifts, because a lot of the issues that arise post-shift stem from the fact that people don’t know if facilities are available, they don’t know where they are, how to access them.”

CLINICAL ACADEMIC WORKFORCE CONTINUES TO SHRINK

The Medical Schools Council recently published the findings of its survey of clinical academic staffing. The council gathered data from all 33 publicly funded UK medical schools on 31 July 2016.

1 NUMBERS

UK medical schools had 3041 full time equivalent clinical academic staff, with a headcount of 3361. This is a 2.1% decline since 2015 and a 4.2% decline since 2010. By comparison, since 2010 the number of NHS consultants has risen by 20.6%.

2 ROLES

The overall decline is partly the result of a 4.2% fall in reader and senior lecturer staff since 2015. Between 2000 and 2016 there was an overall increase in the number of professors, by 29.7%, but this was offset by a decrease of 32.9% in readers and senior lecturers and a 32% decline in lecturer grade staff.

3 FOUR NATIONS

The highest proportion of clinical academics is in England, home to 81% of all UK academic clinical staff, followed by Scotland (13%), Wales (4%), and Northern Ireland (2%). These numbers broadly match the distribution of student numbers at the UK’s 34 publicly funded medical schools.

4 REGIONS

There is a concentration of clinical academic staff in London (31.6%), but this proportion has fallen by 5.5 percentage points since 2015. After London and Scotland, the biggest proportions of clinical academics are found in the North West (7.7%) and the West Midlands (7.1%).

5 SPECIALTIES

Over 40% of clinical academics are physicians, 9.2% are surgeons, 8.1% are psychiatrists, and 7.4% are GPs. The three smallest specialties are medical education, with 17.1 full time equivalent staff, emergency medicine with seven, and occupational medicine with five.

“Rest of UK has much to learn from Scotland”

Governments in other UK nations should adopt Scotland’s “less combative approach” to industrial relations to help breed happier staff who engage more in quality improvement, a report has concluded.

The report, from the Nuffield Trust, said that the NHS in Scotland had benefited from a cooperative spirit and consistency in policy direction. This approach “may be one factor in creating the trust that supports the use of intrinsic motivation for quality improvement,” it concluded.
She added, “By making rest facilities the norm, encouraging people to use them and making them an attractive option for them will gently, over time, shift the culture.”

**Rest rooms at £70**

A 10th of respondents also said that they had to pay for on-call rest rooms, the survey found. “We’ve seen prices of up to £70,” McClelland said, “which, understandably, people don’t want to pay. The calibre of the accommodation is not usually very high.”

The survey also found that trainees were prevented from resting during their shifts by other members of staff. In free text comments, some respondents cited examples of nurses objecting to doctors resting on shift and, in some instances, intentionally disturbing them, the study said.

“Nursing staff are not meant to sleep on their shift. Many do, but it depends on the local policy, and they are far less supported and will often face disciplinary action if they are caught sleeping,” McClelland said. “So, with that attitude towards nursing staff, it does put pressure on us. The expectation is sometimes that we [trainees] mustn’t rest.”

The Association of Anaesthetists of Great Britain and Ireland has established a “Fatigue Group” with the Group of Anaesthetists in Training and the Royal College of Anaesthetists, the paper said. It will look at establishing a “traffic light” grading system for rest facilities, at attitudes towards fatigue in hospitals, and at encouraging anaesthetists to advocate change.

McClelland said, “We’ve developed a set of standards which will be rolled out in the next couple of months. Even though it’s not official guidance, it’s the best that we have been able to come up with, and we hope that trusts will adopt these suggestions and work towards creating some official guidance in the future.”

Abi Rimmer, BMJ Careers

Cite this as: BMJ 2017;358:j3288

**But the report also warned that an impending “intense financial squeeze” threatens to undermine the best aspects of the Scottish service.**

*Learning from Scotland’s NHS* is the first in a series of reports that will examine the health services in the four UK nations to assess their strengths and weaknesses and identify areas where they can learn from each other.

It highlighted that Scotland’s unique system of quality improvement has delivered important changes through the Scottish Patient Safety Programme and equipped a cohort of staff with the skills to implement service change. The report concluded that the Scottish approach “provides possible alternatives for an English system with a tendency towards too many short-term, top-down initiatives that often fail to reach the front line.”

Less positively, the report warned that the Scottish NHS faces a serious financial predicament, as some trusts have to make savings of 8% this year, higher than in other parts of the UK. Limited planning for the next few years and a polarised political context make it difficult to have an honest debate on the future, the report added.

Peter Bennie, chair of BMA Scotland, commented, “While this report rightly highlights some of the lessons that other parts of the UK could learn from Scotland’s NHS, the major difficulties it highlights need to act as a wake-up call.”

Bryan Christie, Edinburgh

Cite this as: BMJ 2017;358:j3285

**GP trainee numbers were rising before scheme was scrapped**

A broad based training programme that was scrapped in 2015 was encouraging more trainees into general practice, including those who were not of a “generalist disposition,” a review of the programme has concluded.

The Academy of Medical Royal Colleges launched the two year programme in 2013 to give trainees experience in general practice, psychiatry, paediatrics, and general medicine. In 2015, however, Health Education England decided to end recruitment to the scheme, although it is still available in Scotland and Wales.

A programme review, conducted by Cardiff University, found that most participants chose to enter GP training, attracting a broad range of trainees, the report noted, “not only those with a generalist disposition.”

Recruiting enough trainees to fill all vacancies in GP training has been difficult in recent years, and in 2014 Health Education England began opening a third round of recruitment to help fill these vacancies.

The Cardiff researchers evaluated the characteristics of the trainees and divided them into three groups: “patients at the centre,” “the working doctor,” and “the open-minded specialist.” Their report said, “It is interesting, and perhaps surprising, that the broad based training participants were spread across all three groups.” It added, “Given the generalist drive of the scheme, we may have expected those on the broad based training programme to align themselves with the first group along with the majority of the GPs. This may suggest that the broad based training programme is not just attracting and developing trainees with a generalist focus but also those who have an open-minded specialist leaning and/or value a work-life balance.”

Broad based trainees were also more self directed and demonstrated leadership and management skills, the report said, and were able to “take a more holistic approach to the care of their patients.”

The authors wrote, “Educational supervisors suggested that these trainees were better equipped to deal with the more complex patients which they linked to their wider perspective. One commented: ‘They were an answer to the future of the training in my view, or the future specialists.’”

Alison Bullock, from the School of Social Sciences at Cardiff University, said that broad based training benefited patients “by giving doctors a wider knowledge and greater skills which are transportable across specialties.” She added that it also gave trainees a “greater sense of self-determination over their career.”

“We are pleased that this training approach has been taken up in Wales and Scotland and hope that in time it will be re-adopted in England too,” said Bullock.

Abi Rimmer, BMJ Careers

Cite this as: BMJ 2017;358:j3260
OUT OF STOCK

Halima Lila, from Tanzania, Sophie, a youth campaigner, and Margaret Bolaji, from the Ugandan Adolescent Youth and Health Forum, join a queue of 214 women, each representing one million women and girls from developing countries, outside a mock “No Contraceptives” clinic in Soho, London, to highlight the plight of those across the world who don’t have access to the contraceptives, advice, and services they need. The protest came on the opening day of the 2017 Family Planning Summit in London, aimed at accelerating access to modern contraception to women in 69 target countries by 2020.

Opening the summit, Melinda Gates, co-chair of the Bill and Melinda Gates Foundation, said that she was “deeply troubled” by President Donald Trump’s proposal to stop US funding for international family planning initiatives.

Speaking on BBC Radio 4’s Today news programme, Gates explained that complications in pregnancy and childbirth were the world’s second cause of death among 15-19 year olds. “We have 1.2 billion adolescents coming of age in the developing world,” she said. “They are having babies too young and too often. But offer them contraceptives, teach them about their bodies, and they take them up—and they space the births of their children and lift their families out of poverty. Contraception is one of greatest antipoverty innovations that we have.” The biggest barrier to access was lack of supply, Gates added.

“We have nearly 220 million women asking for the tools which women use here in the UK. If we provide them, women will take them up. You have to allow local health agencies to deliver the services. They are coming up with their own funding as well.”

Referring to Trump’s proposals, she added, “I’m counting on Congress in the US to hold up funding on family planning. It’s a longstanding bi-partisan issue. For a few dollars a year you can put a young girl on her path to self sufficiency.”

Rebecca Coombes, head of news and views, The BMJ

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#HerFuture

214 MILLION WOMEN AND GIRLS in the world’s poorest countries don’t have the contraception they need

#HerFuture
Liver disease is the second leading cause of potential years of working life lost in England and Wales (72,684), after ischaemic heart disease (77,432). But although years lost from ischaemic heart disease have fallen by a factor of four since 1979, those from liver disease years have increased threefold and are still increasing.1 The increase is in contrast to the trend in Mediterranean regions of Europe (France, Italy, Spain, Portugal, and Greece), which historically had the highest cirrhosis mortality but have seen significant declines. Reduction in alcohol consumption, hepatitis B vaccination, and reduced hepatitis C transmission have contributed to this decrease.2

Liver disease will probably overtake heart disease to become the commonest cause of death in working age people in England and Wales in the next year or so. Only a third of patients admitted to hospital with liver disease will recover. There is no indication that things are improving, and there are at least two reasons for this.

Firstly, therapeutic options for the commonest causes of liver disease, alcohol and obesity, are limited. Secondly, liver disease develops without signs or symptoms, and many patients present with often fatal complications of late stage cirrhosis. Data presented in a Lancet commission report in 2014 indicated that 75% of 5000 patients admitted as an emergency for liver disease in Southampton had not been previously referred to a liver or gastroenterology clinic, suggesting that the liver disease had not been detected beforehand.3

Detection in primary care
Liver disease takes between 10 and 50 years to progress through fibrosis to cirrhosis, portal hypertension, liver failure, and liver cancer. It ought to be possible to detect patients with cirrhosis in primary care, but there diagnosis relies on tests for the enzyme alanine transaminase (ALT), and ALT concentrations are unrelated to stage of liver fibrosis; a recent systematic review found that 90% of patients with cirrhosis would not have been identified using standard liver tests.4

The answer is to go upstream. A 30 year upward trend in mortality from liver disease in the UK was reversed by the 2008 budget, which increased alcohol duty; however, the policy was abolished in 2013, at a cost of £3.5bn in lost duty, and since then liver deaths have been increasing again.5 Similarly, the solution for clinical hepatology is to go upstream; the technologies to identify early liver disease exist and are supported by the National Institute for Health and Care Excellence (NICE).

NICE guidelines
Recent guidelines on cirrhosis from NICE recommend that men and women drinking alcohol at potentially harmful levels—more than 50 and 35 units a week, respectively—be offered transient elastography (Fibroscan) to exclude cirrhosis.6 This equates to about 2.25 million people in England and Wales. Reports suggest elastography is an efficient technique to exclude the diagnosis of cirrhosis whatever the cause. With a cut-off value of 14.6 kPa, chosen to obtain a 95% specificity, positive and negative predictive values for diagnosing cirrhosis are 74% and 96%, respectively.7

Currently few GPs have access to this test so change is not going to happen overnight. However, because the lifetime cost of treating liver disease is between £50,000 and £120,000,8 this approach is likely to be cost effective.

One important question remains: if we detect patients with cirrhosis earlier, can we prevent progression of the disease? There are already highly effective treatments for viral hepatitis and autoimmune liver disease, and numerous compounds are in advanced clinical trials for non-alcoholic fatty liver disease.9 About 40%-50% of patients with alcohol related liver disease will stop drinking after admission with cirrhosis,10 and evidence from a feasibility study shows that a community diagnosis also reduces hazardous drinking.11

We will need properly controlled trials, and these studies are in preparation. However, the burden of liver disease is such that doctors cannot simply sit in their ivory towers waiting for patients with liver disease to come and find them.
Existing brief alcohol interventions have been proved effective in reducing alcohol consumption. Whether they are enhanced by a screening test for cirrhosis is unknown

Evidence is lacking

A focus on the largest group at risk, the three million people in the UK estimated to be drinking alcohol hazardously, highlights where evidence to support screening is lacking.

The test proposed to screen for cirrhosis—transient elastography—is not widely available and would require huge up-front investment to establish it in community settings. It has also been shown to perform poorly in people suspected to have alcohol related liver disease, with a false positive rate of 29%. Using this test to screen all hazardous drinkers would therefore lead to many people being incorrectly labelled as having cirrhosis.

For example, if one million hazardous drinkers were screened and the true prevalence of cirrhosis among them is 10%, about 260000 people would be falsely labelled as having cirrhosis—more than double the true number. These people would subsequently be subjected to unnecessary surveillance interventions—including regular ultrasonography for the early diagnosis of liver cancer and upper gastrointestinal endoscopy for the detection of large oesophageal varices—without any prospect of benefit and the risk of complications. In addition, concerns raised about the complications of cirrhosis, including the development of liver cancer, may cause psychosocial harms.

The most important action for a patient at risk of, or with, alcohol related liver disease is to reduce their alcohol consumption. Whether they are enhanced by a screening test for cirrhosis is unknown. Without this evidence, it is more rational to identify people at risk of cirrhosis and implement interventions known to improve their health. Surveillance interventions for patients with cirrhosis are associated with an uncertain benefit in terms of reducing mortality from liver disease. Surveillance for the development of liver cancer in particular is controversial since it is not supported by randomised controlled trials.

Opportunity costs

Finally, a screening programme for cirrhosis could worsen population health when healthcare resources are limited. Screening for cirrhosis in people who drink alcohol hazardously is probably not cost effective at the £20 000 per quality adjusted life year (QALY) threshold, modelling shows. The true cost effectiveness would likely be even less because the modelling included unrealistically positive estimates of long term abstinence rates after screening.

At that level of cost effectiveness, and given the resource constraints in the NHS, implementation of screening for cirrhosis would inevitably lead to disinvestment in other, more effective interventions, risking the overall health of the population.

Treating the most common liver diseases requires a risk factor based approach—using brief interventions to reduce alcohol consumption and addressing obesity and metabolic risk factors in people with non-alcoholic fatty liver disease—rather than a specific diagnosis of cirrhosis.

Competing interests: See bmj.com.
**DATA BRIEFING**

**Health spending: is there another way to plan?**

**John Appleby** looks at what an independent body might say about NHS funding

In the run up to the June general election there was the usual (unsolicited) advice from interest groups to the main parties on what they might like to do once in government. One suggestion made by several people was the need for an independent group to periodically make recommendations about future levels of health (and possibly social) care spending. In the manner of headlines, this got abbreviated to an “OBR for health.” But what does it mean? And why would such an exercise be worthwhile?

In some ways an OBR for health already exists—it’s called, well, the OBR (the Office for Budgetary Responsibility). Set up by George Osborne in 2010, it provides “independent and authoritative analysis of the UK’s public finances.” Part of its job is to produce regular projections of public spending (such as on healthcare), tax revenues, and other economic measures such as gross domestic product (GDP) up to decades ahead. In many ways this continues work that used to be done within the Treasury (fig 1) but is now conducted in a more transparent and, as the OBR advertise, independent manner.

Similar organisations exist in other countries—for example, the Congressional Budget Office in the US also produces long term public spending projections (fig 2).

The OBR’s most recent projections for healthcare suggest that by 2066-67, UK health spending could be anything from 8.1% to 15.2% of GDP, from a starting point of 6.9% in 2020-21. The variation in projections reflects uncertainty.
about the future—modelled by varying assumption about, for example, future population health and NHS efficiency. (fig 3) It is interesting to note that lower net migration feeds through to higher healthcare spending as a proportion of GDP, mainly because the population changes result in lower growth in GDP relative to the savings on health spending. Actual cash spending on healthcare may be lower than in the OBR’s “high migration” model, but the loss of GDP is likely to outweigh this.

These OBR projections are not forecasts; they are policy neutral. They do not indicate how much an NHS we would like to have will cost in the future. Rather they use what we know drives pressures to spend—population changes, supply induced demand through technological innovations, etc—to produce possible future spending paths.

A different approach to future NHS spending, one based more on a vision of what we might like the NHS to look like (shorter waiting times, better outcomes, etc), was the basis for Derek Wanless’s 2002 report for the then chancellor, Gordon Brown (fig 4). Wanless also called for his sort of analysis to be carried out every few years to take account of new evidence of medical and other changes to inform spending decisions. This suggestion was reiterated in a review of NHS spending and performance in 2007 and again in evidence to the House of Lords committee investigating the long term sustainability of the NHS.

Nevertheless, the main aim of a Wanless-style future spending review was not just to set out the pressures on spending (like the policy neutral OBR approach) but to detail the costs of achieving the sorts of outcomes and user experience we might expect from the NHS in future. In doing so, Wanless believed, the necessary public and political debate about funding would be better informed, with argument more appropriately focused on the trade-offs and the values involved in future spending paths. In short, if you want this sort of health service, this is what it will cost. And if the political decision is not to choose a particular spending line, then it is clear to everyone what opportunity costs such decisions entail.

The variation in projections reflects uncertainty about the future—modelled by varying assumption about, for example, future population health and NHS efficiency.
As we cross the midpoint for the NHS Five Year Forward View, and with the publication of this year’s Next Steps plan, its implementation remains critical to the delivery of sustainable high quality healthcare in the UK. A key to making this successful is the use of digital technology and informatics, both of which help foster innovation.

Last year, a report commissioned by the health secretary from Robert Wachter, an American clinician-informatician, made recommendations to help accelerate the introduction of health information and communication systems, with a particular focus on engaging and training the workforce, especially clinicians. His review recognised that the NHS in England currently lacks clinicians with the necessary skills in healthcare improvement and redesign of care enabled by digital health and informatics.

Leaders in this arena are commonly referred to as chief clinical information officers (CCIOs). This is an emerging role in global health systems, including the NHS. Both the responsibilities of the role and the scope of practice vary across the system and remain defined by local context. However, wherever they work CCIOs need a wide range of competencies in research, data analytics, leadership, and management, and a strong understanding of health informatics and the health and care system.

The NHS in England needs to place such people in authoritative positions with the autonomy to make strategic decisions and to develop and manage high performance teams.

**Clinicians first**

A CCIO or clinical informatics leader requires competencies in both information technology and leadership, but first and foremost they must be clinical professionals with front line experience of patient care.

The CCIOs will also need a portfolio of data analytical and research skills complementing their clinical skills. This will enable them to drive systematic learning across their organisations, so every member of the workforce routinely uses real time data and information to inform decisions.

To achieve all this, the CCIO will need to understand the importance of user centred design of technology platforms and understand the critical role of patients and carers in stimulating and fostering innovation throughout healthcare. Working with patients, carers, and the wider public will ensure that digital technology is embedded in each organisation’s strategic and operational plan for delivering the triple aim of healthcare—better patient outcomes, better patient experience, and affordability.

This new role must be seen as a genuine professional opportunity, alongside more traditional clinical professional roles. CCIOs must have enough authority to be able to have an effect across health and care systems.

Since 2009, the US has made substantial progress in this area. Respected universities and healthcare organisations have increased the number of informatics fellowships by more than 50%, expanded their health informatics capability, and substantially increased the number of senior leadership positions in informatics and digital transformation.

**Dual careers**

Over the past decade, the UK has seen structured careers develop in academic medicine following the Walport report, and clinicians can now train as academic clinical fellows. Leadership in informatics must now be given the same priority, with the same prospect for dual careers.

This emerging specialty requires rigorous and accredited training and professional recognition as recommended in Wachter’s review and enshrined in the National Information Board’s Personalised Health and Care 2020 programme. The launch of the NHS Digital Academy in September should help accelerate this progress, with accreditation and professional recognition coming from the newly formed Faculty of Clinical Informatics.

The academy will offer professionally recognised training, aiming to develop a cohort of 300 informatics leaders over the next few years. They will drive the digital agenda across the NHS, maximising the benefits of modern technology to improve patient outcomes and ensure sustainable and affordable health care well into the 21st century.

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Shortage of general practitioners in the NHS

GPs are a scarce resource that must be deployed more wisely

Ensuring sufficient primary care doctors is a key challenge for health planners globally because of the important role that primary care plays in supporting cost effective health systems that promote equity in health outcomes. For example, the US is predicted to need 7800 to 32 000 additional primary care physicians by 2025.

We know the UK’s NHS is also short of general practitioners, but we do not know the size of the shortage or how many additional GPs it needs to provide comprehensive primary care services.

In its plan for general practice published in 2016, NHS England set a target of 5000 additional general practitioners by 2020. However, no data were presented to show that this would be enough to meet the country’s needs. An analysis from Imperial College suggests that NHS England has substantially underestimated the current shortage of GPs and the numbers required to plug the gap. It estimates that in 2016, the NHS in England was already around 6500 GPs below the ideal number, rising to 12 100 short by 2020. Given that recruitment to general practice training schemes in England remains below target, shortages of GPs will inevitably continue into the foreseeable future.

Workforce planning is hindered by the lack of accurate and timely data on workload in primary care and the lack of accurate information on the number of GPs working in the NHS. The NHS does not routinely collect or publish information on the workload of general practices (in contrast to hospital activity, where workload statistics are published regularly). Information on the number of GPs working in the NHS is also limited. Improving these data would be a useful start. But more radical solutions are also required.

One important step to aid recruitment would be to link primary care funding to workload through the implementation of workload based funding for general practices. Since the NHS was established in 1948, core funding of general practice has been capitation based. However, this model increasingly looks unfit for the 21st century. With activity based funding, general practices would be paid for the work that they do, and practices would take on new work only if the funding met the full costs of providing the service.

Funding options
Activity based funding would be considerably more costly to the NHS than the current method of funding. The government would therefore have to decide whether to fund general practice entirely from taxation; part fund it from taxation and allow general practices to charge patients to make up the difference; or scale back the services that general practices offer to fit in with the public funding that was available. All these options are problematic but as the current situation is not sustainable, a decision is urgently needed.

The NHS should also examine the extent to which work done by GPs could be carried out by other professionals such as nurses, physician assistants, healthcare assistants, pharmacists, and physiotherapists. For example, programmes that allow patients to see physiotherapists directly without requiring a referral from a GP can help reduce demands on general practices and provide an alternative, cost effective care pathway for patients with musculoskeletal problems.

Accessible services
More NHS services should be accessible by patients without a referral from a GP—for example, exercise and weight reduction programmes, antenatal services, podiatry, termination of pregnancy services, and services for drugs and alcohol misuse.

An increasing administrative burden on physicians is a global phenomenon, a barrier to primary care recruitment in the UK and elsewhere, and a brake on efficiency. Reducing it should be a government priority, starting with a detailed review of all non-clinical tasks done by GPs with the aim of removing as many as possible to free up more time for clinical work.

The NHS must also do more to encourage doctors to return to clinical practice after career breaks for family or other commitments. We cannot afford to waste the skills and commitment of this important group, or write off the public investment in their training. Key barriers to return to work include the high indemnity payments that doctors now must pay, which can be unaffordable for doctors working part time or considering out-of-hours work, and the inadequate child care support offered to doctors with families.

Measures must be taken to remove barriers to recruitment and retention while we put the systems in place to measure, track, and ultimately fix this threat to the sustainability of the health service.

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An analysis suggests NHS England has substantially underestimated the numbers required to plug the gap

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Pharma’s new UK leader: Drs, Brexit and transparency

The industry is on a long march to transparency, including in its relations with doctors, Lisa Anson (right), the new ABPI head, tells Anne Gulland

The Association of the British Pharmaceutical Industry last month released the latest tranche of data on drug company payments to doctors and other healthcare professionals, showing a total of £454.5m in 2016.

Disclosure of payments is voluntary and recipients can choose anonymity. However, the number of doctors and other professionals who are willing to be identified increased from 16087 (55%) in 2015 to 16920 (65%) in 2016. But some who receive the larger amounts have withheld their names and account for 40% of payments, excluding those for clinical research. This means, one third of payments—around £150m—is undeclared.

Transparency is a word that Lisa Anson, president of the ABPI since April, is keen on, and she is encouraged by the increase in doctors willing to be identified. They have nothing to be ashamed of in their relationships with pharma, she says. “Medical progress and treating patients to the best possible standard is a partnership. Encouraging doctors to see partnership as a good thing—and that there is nothing to hide—is a good thing,” she says.

Ben Goldacre, academic lead at the Evidence Based Medicine DataLab at the University of Oxford, pointed out numerous problems with the ABPI data when he helped The BMJ analyse them last year. Problems include publishing undisclosed payments as an aggregate rather than as an anonymised list, which makes it impossible to calculate the number of undisclosed payments. These problems remain, although the website is now easier to navigate.

Anson was surprised to hear that these data were not easy to interpret and added that the way they are published will be refined. She also highlights the ABPI’s role in putting these data in one place, rather than allowing individual companies to publish data piecemeal, as is the case elsewhere in Europe, such as Germany.

But Anson does not believe disclosure should be mandatory as it is in the US: “There are data privacy issues so it’s not within the scope of the ABPI to say this should be mandatory. But I actually think it’s better if doctors want to do it.”

Reputation building

Would pharma’s reputation improve if it were more transparent, particularly around clinical trial data?

“The most recent research we have done with Livewire shows disclosure of [results] of trials has moved from 70% to 90%—a significant improvement. Maintaining that momentum with transparency is critical. It’s true for trials, true for payments.”

The research, funded by the ABPI, looked at 392 company sponsored trials that had been published in the scientific literature or had data posted in a registry. The paper does not spell out the proportion of trials that used each of these two options. Organisations such as AllTrials, which campaign for disclosure, say results should be disclosed in a registry, rather than solely published in journals.

Brexit uncertainty

One of the most pressing matters in Anson’s in-tray is Brexit. The life sciences sector was one of the first to warn of the potential harms of quitting the EU. A year on, with little clarity on what the UK will look like after Brexit, Anson warns “time is running out” to get a deal that will safeguard the life sciences and pharmaceutical sectors.

Anson says that the ABPI has been working “intensively” with government and that its hard lobbying may have paid off—health secretary Jeremy Hunt and business secretary Greg Clark wrote to the Financial Times this month saying they wanted to “work closely” with the EMA.

Much has been said about drug companies quitting the UK but so far there has been little evidence on the ground, says Anson, apart from some industry chatter around key appointments. She adds, “We can’t leave getting a deal to the end of the two year [negotiating period]. That’s why I’m saying time is running out. We need progress this year.”

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Full version with references on bmj.com

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