this week

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SPL

Adult ADHD prescribing left to GPs

GPs have warned that they are being placed in an "invidious position" to prescribe drugs to adults with attention-deficit/hyperactivity disorder (ADHD) without specialist support, after a treatment service led by an NHS trust stopped taking new patients because of high demand.

Norfolk and Waveney Local Medical Committee raised concerns with five clinical commissioning groups after NHS England wrote to GPs notifying them that the trust was implementing an immediate pause in new referrals because of capacity pressures. The letter was drafted on behalf of the CCGs and Norfolk and Suffolk NHS Foundation Trust.

Ian Hume, chairman of Norfolk and Waveney LMC, told *The BMJ* that some patients were now facing waits of up to a year for specialist support.

"We [GPs] pushed for a service and they commissioned one about a year ago with a referral pathway into it. But it's now swamped. They didn't commission enough capacity and there is potentially a year wait for patients to be seen," he said.

An extract from the letter, re-published by the LMC, states, "To ensure that the service remains safe it has been agreed that a pause in new, routine referrals needs to be immediately implemented. This will enable clinical teams to triage and support existing referrals and reduce waiting lists."

But Hume said that GPs may feel under pressure from patients to prescribe if patients cannot access the specialist service, which risked contravening GMC guidelines if they prescribed beyond their capability. "It leaves GPs in an invidious position. Should they prescribe drugs without specialist support?" said Hume. "We are saying it is not acceptable for GPs to be under pressure to prescribe drugs. We've written to the CCGs and asked them to commission an appropriate service."

A spokesperson for North Norfolk, South Norfolk, Norwich and Great Yarmouth, and Waveney CCGs said they were working with all partners to find "a swift resolution."

A spokesperson for Norfolk and Suffolk NHS Foundation Trust said new referral numbers had far exceeded estimates when the service was commissioned. "GPs have been given direct phone access to the service's nurse specialist and consultant psychiatrist for any concerns they may have with a particular patient or with existing ADHD patients' drugs," they added.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;358:j4444

GPs say they feel under pressure to prescribe specialist drugs to adults with ADHD because a trust-led service has stopped taking new referrals

LATEST ONLINE

- BMA urges more career flexibility and better occupational support to fight workforce crisis
- Doctors can withdraw artificial feeding without court approval in some cases
- Labour's Jonathan Ashworth calls for £500m winter bailout fund

SEVEN DAYS IN

TP BENNETT

Woman's payout includes costs for surrogacy

The High Court in London has awarded damages covering the cost of surrogacy for the first time to a woman who lost her fertility through a hospital's negligence.

Whittington Hospital NHS Trust in north London admitted liability in the case of the woman, who was diagnosed as having invasive cervical cancer at the age of 29. The trust failed to detect cancer despite smear tests in 2008 and 2012 and biopsies in 2012 and 2013. The woman underwent chemoradiotherapy, which left her infertile and with severe radiation damage to her bladder, bowel, and vagina.

While admitting liability, the trust disputed some elements of the damages claimed, including the payment for surrogacy. Robert Nelson, the judge, awarded her a total of £580 618, including £74 000 for two surrogacies.

The cancer was diagnosed too late for the patient to have fertility sparing surgery, but she had 12 eggs harvested and frozen before starting treatment. She told the court that she preferred to have the treatment in California, where commercial surrogacy is legal and binding. But the judge rejected this option saying: "Commercial surrogacy arrangements are still illegal in the UK and thus contrary to public policy."

Clare Dyer, *The BMJ* **Cite this as: *BMJ* 2017;358:j4357**

Medical registration

Tax evading consultant is suspended

A "world renowned" consultant radiologist has been suspended from the medical register for six months after being convicted of failing to pay more than £400 000 in tax on his private practice earnings. Raad Mohiaddin, professor of cardiovascular imaging at the National Heart and Lung Institute in London, was given a 15 month suspended prison sentence and fined £200 000 in 2015. The GMC argued that he should be erased from the register. But the medical practitioners tribunal concluded that he made a unique contribution to the care of critically ill patients and the development of cutting edge techniques.

Abortion law

RCOG adopts stance to back decriminalisation

The council of the Royal College of Obstetricians and Gynaecologists has voted in favour of removing criminal sanctions associated with abortion. The college said that it had adopted a formal position saying that "the procedure should be subject to regulatory and professional standards, in line with other medical procedures, rather than criminal sanctions." In June the BMA's annual meeting voted in favour of decriminalising abortion, and the Royal College of Midwives has supported the change since 2016. Currently a woman who has a termination after buying abortion pills online risks being prosecuted for not having the approval of two doctors for an abortion.

Smoking cessation

Stoptober backs e-cigarettes for first time

TV advertisements for "Stoptober," Public Health England's annual campaign for people to quit smoking, will feature e-cigarettes for the first time this year after the devices proved to be the most popular cessation aid in last year's campaign. New draft guidance from NICE on smoking cessation says that smokers should be asked about their use of e-cigarettes and told that although these products are not licensed they are regulated by the Tobacco and Related Products Regulations 2016. They should also be told that some smokers have found them helpful to quit.

FEATURE, p 475

NICE guidance

Changes to Lyme disease diagnosis

Doctors can diagnose Lyme disease in people who have a circular red rash, known as erythema migrans, after a tick bite without the need for tests, says NICE in draft guidance. And Lyme disease should not be ruled out if a person has symptoms consistent with the condition but they are not sure that they've been bitten by a tick. People without a rash but with symptoms should be referred for tests. If results are negative doctors should seek specialist advice.

No need for antibiotics in most otitis media cases

Most cases of otitis media in children can be managed with paracetamol or ibuprofen rather than antibiotics, says new draft NICE guidance. Antibiotics make little difference to how long symptoms last or the proportion of children whose symptoms improve, it says. There is also evidence that antibiotics make little difference to the proportion of children with recurrent infections, hearing loss, or perforated ear drum, while acute complications, such as mastoiditis, are rare whether antibiotics are given or not. But there is evidence that adverse effects, particularly diarrhoea and nausea, occur in those who take antibiotics.

Research news

Effect of exercise on death quantified

Being physically active for the WHO target of 150 minutes a week could prevent one in 12 deaths globally and one in 20 cases of cardiovascular disease, a study of 130 843 healthy volunteers from 17 countries has found. Results, reported in the *Lancet*, showed that people who had 150 minutes of moderate intensity physical activity a week had a 28% lower risk of death from all causes and a 20% lower risk of major cardiovascular disease and cardiovascular death than people who were less physically active. Higher physical activity of up to 750 minutes a week reduced the risks further.

MEDICINE

Drug regulation

Pregabalin and gabapentin to become class C drugs

The Home Office has proposed reclassifying pregabalin and gabapentin as class C controlled substances after concerns were raised that they were being given to patients too readily, with prescribing increasing by 350% for pregabalin and 150% for gabapentin in just five years. In England and Wales the number of deaths linked to pregabalin rose from four to 111 and those linked to gabapentin rose from eight to 59 between 2012 and 2016.

A public consultation on pregabalin and gabapentin is to launch shortly

Neonatal care

One in 10 parents don't see consultant within 24 hours

The care delivered in 2016 to around 95 000 babies admitted to UK neonatal units was better than in 2015, the National Neonatal Audit Programme found. But practice varied, with administration rates of antenatal magnesium sulphate ranging from 26% to 70% across neonatal networks. That only nine in 10 parents saw a consultant within 24 hours of their baby being admitted was "sad," said Anne Greenough, chair of the audit. Units could learn from those with the best practice, she said.

General practice

Investment reduces hospital costs

Increasing capitation supplements to general practices in England was associated with lower use of secondary care, mainly in terms of fewer A&E attendances and admissions, a study by researchers from King's College London found. Financial modelling indicated that doubling the capitation supplements, at a cost of £5720 per 1000 registered patients, would result in an overall saving of 9.8% in secondary care costs.

15% of AF patients get no stroke prevention

Over 15% of patients with non-valvular atrial fibrillation get no antithrombotic agents at all, a study in *BMJ Open* has found. Between 2012 and 2016 the proportion of patients to whom anticoagulants were prescribed rose by 17 percentage points (from 50.2% to 66.9%), the proportion treated with an antiplatelet agent alone almost halved (from 34.2% to 17.4%), and the proportion of patients not receiving any antithrombotic treatment remained steady.

HIV

One in six newly diagnosed Europeans is aged over 50

Of the 29 419 new cases of HIV diagnosed in Europe in 2015, 5076 (17%) were in people over 50, shows a study in *Lancet HIV*. While the incidence remained steady in people aged 15-49 between 2004 and 2015 (11.4 cases in 100 000 people), in older people it rose from 2.1 new cases in every 100 000 people to 2.5 per 100 000.

Cite this as: *BMJ* 2017;358:j4462

TRAINEE PAY

Medical graduates earn **£30 000** six months after graduating on average, second only to dentists, who earn **£31 000** six months after graduation, while graduates of veterinary science earn **£28 000**.

Times Good University Guide

SIXTY SECONDS ON . . . HOOKWORM

THE PARASITE THAT'S ENDEMIC IN POOR COUNTRIES?

Yes, that's right, the parasite, thought to affect about 450 million people globally, is common in countries with poor sanitation. But it's also been found in one of the richest countries in the world: the United States.

I THOUGHT IT HAD BEEN ERADICATED?

Hookworm infection, historically a big problem in the southern US states, was thought to have been wiped out in the 1950s. However, a community organisation, the Alabama Center for Rural Enterprise, was concerned at the number of communities that are forced to dispose of their waste in the open because they cannot afford sewage systems. It asked researchers from the Baylor College of Medicine to investigate.

WHAT DID THE RESEARCHERS FIND?

A survey of 24 households in Lowndes County found that 42.4% reported exposure to raw sewage. From 55 stool samples 19 (34.5%) tested positive for *Necator americanus* (hookworm) and four tested positive for *Strongyloides stercoralis* (threadworm).

WHAT'S BEEN THE REACTION?

Catherine Flowers, from the Alabama centre, says it has validated her "long held belief that raw sewage within the US is currently yielding tropical illnesses." She hopes the findings will improve sanitation in the area.

HOW DO PEOPLE BECOME INFECTED?

By walking barefoot in contaminated soil. Children can also pick it up by playing in the soil and then touching their mouths.

WHAT ARE THE SYMPTOMS?

Severe infection can cause weight loss, diarrhoea, and abdominal pain. Long term it can cause iron deficiency, impaired cognitive development, and stunting in children. In the US, hookworm was known as the "germ of laziness" as its victims succumbed to lethargy and fatigue.

IS IT EASY TO TREAT?

Yes, with a short course of anthelmintics, although a *BMJ* study shows that some are losing their efficacy. But the root cause of the problem—poor sanitation—needs to be tackled as people can become reinfected. Hookworm is a disease of poverty and that, of course, is hard to treat.

Anne Gulland, London

Cite this as: *BMJ* 2017;358:j4423

Bosses reject GPs' request to close lists

A group of general practices in Kent that applied to formally close their practice lists because of safety concerns have had their request knocked back by NHS bosses, *The BMJ* has learnt.

Earlier this month seven of eight practices in Folkestone applied for permission to close their patient lists on the basis that they were "unable to take on more patients safely." The action was triggered after one local practice was forced to hand its contract back to South Kent Coast Clinical Commissioning Group in May, prompting the CCG to order that the practice's 4700 patients be reallocated to other local practices.

But the CCG rejected the practices' application after a meeting held on Thursday 21 September.

In a statement Jonathan Bryant, chair of South Kent Coast CCG, said, "It is clear that allowing seven practices in Folkestone to close their lists to new patients would have a negative impact on local people. Everyone has a legal right to be registered with a GP practice, and the CCG has a legal responsibility to ensure this. We have no choice therefore but to decline these applications."

Patient safety

Gaurav Gupta, chair of Kent Local Medical Committee, told *The BMJ* that the practices were considering appealing the decision on the grounds that they did not have the capacity or resources to treat the patients safely. "The issue that we have now is one of patient safety, because these practices are very clearly saying that they cannot handle any more patients in a safe manner," he said.

Gupta added that closing lists was one of the only mechanisms that practices could use to ensure that they were able to provide a safe level of care to patients.

He said, "It's a clinical risk, and this is where there is a big problem for general practice. If you look at other parts of the NHS, even in A&E, they can declare a major alert and divert patients to another hospital. But there is no way for general practice to declare something like a black alert and say, 'We are full and we cannot see any more patients in a safe manner.'"

Gupta, who said that Folkestone had a shortage of 16 full time equivalent GPs, said it was crucial to find a long term and sustainable solution to the crisis. But he added, "There [also] needs to be significant urgent intervention now, while the long term solution is being made."

The CCG said that practices

"These practices are very clearly saying that they cannot handle any more patients in a safe manner"
—LMC chair

Patients with serious injury more likely to survive if they go to hospital by "scoop and run" than by ambulance

Researchers have discovered what gang members have known all along—that you're more likely to survive a serious injury if you get yourself to hospital than if you wait for an ambulance.

"Scoop and run" describes the most basic form of prehospital trauma care—transportation with no intervention. A study from 2014 found that patients who used private transportation had better survival than those who waited for an ambulance. But researchers from Johns Hopkins University School of Medicine wanted to investigate survival according to the prehospital care on a larger whole system scale.

They analysed the outcomes of 103 029 people who were treated for a gunshot or stab wound between January 2010 and December 2012 in the 100 most populated trauma centres in the US, whose data are collected in the National Trauma Data Bank.

They reported in *JAMA Surgery* that unadjusted mortality was lower for those who had got to hospital by private vehicle (378 deaths, 2.2%) than by ambulance (9986, 11.6%). The same trend was seen in both types of injury (gunshot wounds mortality 0.3% *v* 4.5%; stab wounds 0.2% *v* 2.9%).

Inform trauma systems policy

After risk adjustment, patients with penetrating injuries transported by private vehicle were significantly less likely to die than patients transported by ambulance.

The researchers wrote that their results "are important because they identify a component of prehospital trauma care that is associated with significant differences in mortality and may present an opportunity to improve trauma care at the system level."

They said that their findings could inform trauma system policies—for example, by "educating those at high risk for penetrating injury that people with these injuries may benefit from rapid private vehicle transport to the nearest level 1 trauma centre instead of waiting for first responders to arrive."

In response to the study, Karim Brohi, a trauma surgeon at the Royal London Hospital and director of the London Major Trauma System, tweeted: "London 'gangs' already self-triage and will drive past 2 or more trauma units to take their mates to a major trauma centre."

A tweet from @Mapelson F said: "The Birmingham ones do as well."

Another tweeter and medic, @momedic9019, tweeted: "We call it the 'Homeboy Ambulance Network' in the US."

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2017;358:j4430

50 Cent was shot in 2000 and drove himself to hospital

UNADJUSTED MORTALITY was lower for those who had got to hospital by private vehicle (378 deaths, 2.2%) than by ambulance (9986, 11.6%)

in Folkestone would be paid an additional £42.68 per patient to meet additional costs of registering patients for the first year. It added that Kent and Medway was one of the areas chosen by NHS England to receive additional overseas GPs, and that it planned to build a new primary care centre in Folkestone in the longer term.

The crisis in Folkestone comes as many practices across the country increasingly consider the option of applying to close their lists in the face of huge workload pressures.

A BMA ballot of GPs, carried out after a vote at this year's annual conference of LMCs, showed that 54% were prepared to temporarily close their lists to new patients, while two fifths were prepared to close them permanently.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;358:j4433

Doctor is cleared of wrongdoing after patient "misremembered"

A junior doctor who was accused of wrongly telling a patient that he had cancer has been exonerated after a medical practitioners tribunal found that the patient had become flustered at the mention of the word "cancer" and misunderstood the doctor's comments.

Richard Schofield, who qualified in 2011, waited nearly three years for his hearing, only for the General Medical Council's case against him to unravel.

The two expert witnesses, one for the GMC and one for Schofield, wrote in a joint statement, "The experts agree that in their experience it is common for patients of all ages, when faced with 'bad' news (including, for example, the possibility that they may have cancer), to become less receptive to receiving information. Both experts have witnessed this phenomenon in their working lives."

Schofield, who was working at Warrington General Hospital as a foundation year 2 doctor in general surgery, saw "Patient A" in June 2014 to explain that he had a potentially suspicious lesion on one kidney, which he recalled saying might be cancerous and might not. Eight days later a nurse told him that she had spoken to Patient A, who believed that he had aggressive cancer. Schofield called him the same day to clarify the situation.

The patient's recollection was very different. He suggested that Schofield had said that he had "aggressive cancer" of the kidney. When asked if a person could live on one kidney, the patient said, Schofield had answered, "Nah."

The tribunal preferred Schofield's version of events. It was inherently unlikely, said the tribunal chair, Victoria Goodfellow, that he had denied that a person could survive on one kidney.

In his letter of complaint to the trust Patient A said that his mind went into turmoil after hearing the word "cancer."

Goodfellow told Schofield, "The tribunal concluded that whilst Patient A was endeavouring to be honest and give a true account of the consultation, it is more likely that Patient A misremembered what happened."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;358:j4425

FIVE MINUTES WITH . . .

Tom Treasure

The cardiothoracic surgeon describes the birth of heart surgery

"My book looks at the 'heart club,' a team of London doctors and scientists who, in the late 1940s, took the decision to operate on children with Fallot's tetralogy, at a time when any kind of heart surgery was contraindicated. The club kept meticulous notes, which sat on the shelves of the cardiology department at Guy's until I got hold of them when the building was demolished in the 1990s.

"What's interesting about these notes is that they form a consecutive record, which includes all their failures, disappointments, and frustrations.

"The book is a bit of a mixture—there is a transcript of the notes, a look at contemporary history, as well as first person accounts of patients who were operated on as young children.

"There had been some heart operations in the 1920s but there was a line drawn under them as they were, in the main, unsuccessful. Everyone insisted that operating on the heart was too dangerous.

I'M AMAZED BY THE HEART CLUB'S WILLINGNESS TO GO INTO THE UNKNOWN, BY THEIR TENACITY

"But the change came when, during the war, Russell Brock, a thoracic surgeon at Guy's, spent time with [US surgeon] Dwight Harken at a US army hospital based in England. Brock watched Harken remove bits of shrapnel from the hearts of wounded soldiers.

"In the late 1940s people were operating close to the heart and Brock decided to form this heart club. He needed support, people to watch his back, because the risk was so high. Surgeons, cardiologists, and anaesthetists banded together with great success.

"The Guy's group were high quality chaps. They clearly had a process—they made measurements and did imaging of the heart. Then they went to the operating theatre—if things went well they were pleased, but if not they went back and looked at their flaws. I'm amazed by their willingness to go into the unknown, by their tenacity in the face of disappointments and setbacks."

Tom Treasure is author of *The Heart Club: A History of London's Heart Surgery Pioneers*

Anne Gulland, London

Cite this as: *BMJ* 2017;358:j4472

NEWS ANALYSIS

Don't punish struggling practices, say GP leaders

Negative headlines about general practice ignored many recent achievements, reports **Abi Rimmer**

Headlines generated last week by a report from England's health services inspectorate, which found that 90% of general practices had been rated as "good" or "outstanding," may have raised more than a few eyebrows.

"One in seven GP practices in England failing on safety," declared the *Guardian*, while the *Times* reported that "7m patients are urged to leave unsafe GP surgeries."

I DIDN'T SAY THAT SEVEN MILLION PEOPLE SHOULD [SWITCH PRACTICES]

Steve Field (left), chief inspector of general practice at the Care Quality Commission, said that his agency's report had been intended to be a good news story for general practice. "Nearly 90% of practices are either good or outstanding, and some of the outstanding ones are absolutely amazing," he said. "Of course, a few aren't."

The *Times* headline was sparked by Field's comments that he had visited a practice that had seen an increase in patient numbers after a positive CQC rating. "I didn't say that seven million people should [switch practices]—I was astonished that was a headline," Field said. "I said that there is some evidence that some patients are moving if [practices] are rated outstanding, and secondly that some of those outstanding practices are also telling us that they are not having a problem with recruitment of doctors any more, compared with other local practices.

Negative focus

Richard Vautrey, chair of the BMA's General Practitioners Committee, said that he raised his "deep disappointment" about the report's coverage with the CQC. He pointed out that many practices that had been struggling previously had tackled deficiencies. "That suggests that with the right support, and the right help, even those practices that are deemed to be needing improvement can actually make that improvement very quickly."

Martin Marshall, vice chair of the Royal College of General Practitioners, echoed Vautrey's frustration. "Nine out of 10 practices are doing either well or outstandingly in an environment that's really tough. That is remarkable and something to celebrate." He said that it was unlikely that patients would leave a practice that was given a poor CQC rating because they don't "behave like consumers."

No room for more patients

Even if patients wanted to leave a practice, Marshall said, other practices would probably not have the capacity to take them. "Our emphasis must be on supporting the practices that are struggling in order to do better, so that everybody has good access to care, rather than pretending that we have enough flexibility in the system to allow patients to make a move."

Michelle Drage, chief executive of Londonwide Local Medical Committees, backed Marshall's call. "When people are struggling, the last thing you want to do is make things harder, and [yet] that tends to be what happens," she said.

In London 17% of practices were inadequate or required improvement, the CQC found. "It's not surprising that London GPs are struggling, given the long term funding shortages that we've got across the health service in London, not necessarily just general practice. We're all vying for the same depleted pot," Drage said.

Abi Rimmer, *The BMJ*

Cite this as: BMJ 2017;358:j4463

Patient murders urologist 21 years after diagnosis

"Whatever went wrong in his life he'd blame on the procedure," said prosecutor Matt Murphy

A Californian urologist who helped to diagnose urethral stricture in a patient was murdered two decades later by the same man, who was convinced that the resulting operation—in which the urologist took no part—had ruined his life.

Stanwood Elkus, 79, was sentenced to life in prison without parole for the murder of Ronald Gilbert, who was 53 in 2013 when Elkus booked an appointment under a false name, then shot him 10 times as he walked through the consulting room door. He told a nurse as he emerged: "I'm

Children who had the Lightning Process missed fewer school days

insane. Call the police."

The retired barber's grudge dated from 1992, when he complained of frequent urination at the Veterans' Affairs Hospital in Long Beach, California. Gilbert was part of a team that diagnosed urethral stricture and recommended surgery to widen it, a simple outpatient procedure that was performed by two other doctors. Immediately afterwards, Elkus argued with nurses, as he was reluctant to leave the hospital until he was "fully healed." Days later he returned and demanded that doctors remove his temporary catheter.

Elkus became convinced that the procedure had damaged his prostate and, prosecutors said, would tell "anyone who would listen" that it had caused incontinence, erectile dysfunction, and diminished sex drive. He eventually blamed the surgery for the departure of his longtime girlfriend, whom he had hoped to marry.

He visited several urologists, taking with him a stack of medical records and a tape recording of his girlfriend discussing his sexual problems. Some told him that he had received a misdiagnosis and that his procedure had been unnecessary, said Elkus's attorney Colleen O'Hara. "It was further confirmation that his suffering was for naught," she said.

"Whatever went wrong in his life he'd blame on the procedure," prosecutor Matt Murphy told jurors.

Meanwhile, Gilbert's career flourished. He founded a company specialising in treatments for sexual dysfunction. The day before his death, he was offered $30m (£22m) for it by a buyer.

Elkus pleaded not guilty by reason of insanity. His lawyers claimed that he had not intended to kill Gilbert at the appointment but had begun taking an antidepressant days before, which had weakened his inhibitions. They also argued that he had dementia.

But jurors rejected this plea. Elkus had bought a pistol and practised shooting it in the weeks before the appointment. He had also wound up his financial affairs.

Glenn Gilbert, the doctor's brother, said in his victim impact statement that the urethral operation "was botched by the murderer himself by his insistence on altering the postop protocol."

Owen Dyer, Montreal

Cite this as: *BMJ* 2017;358:j4363

Stanwood Elkus (top) removed his hearing aid for the victim impact statement; Ronald Gilbert's family (below) in the courtroom

Training for children with chronic fatigue works better than medical care alone

A widely publicised technique for treating chronic fatigue syndrome in children actually works, to the surprise of the researcher who conducted the first randomised controlled trial of it.

The Lightning Process, developed by osteopath Phil Parker, has made bold claims that it can cure CFS in children. It is not available on the NHS, costs around £620 per case treated, and details are scarce.

Esther Crawley, professor of child health at the University of Bristol, runs a clinic for children with CFS. She conducted a randomised controlled trial comparing specialised medical care, of the sort her unit already provided, with the same care together with the Lightning Process.

"I never expected it would work," she told a briefing at the Science Media Centre in London. But the trial, published in *Archives of Disease in Childhood*, showed positive results. The primary endpoint was physical function, measured by a self reported questionnaire and using a recognised scale.

Children aged between 12 and 18 randomised to specialist care plus the Lightning Process showed improvements six months later roughly twice as often as those given specialised medical care alone. At 12 months the gap had widened. Secondary outcomes such as the number of school days missed also showed improvements.

Of those whose physical function declined during the trial, eight were in the control group and one in the Lightning Group. Adverse effects were minor. Recruitment was difficult and of 316 possible children only 100 were recruited.

"I was surprised that the Lightning Process provided additional benefit," Crawley said. "This is an important study as it provides another treatment approach that some may find helpful. However, while these results are promising, further research is needed to establish which aspects of the process are helpful, whether it is an effective treatment on its own, and whether it could be used to help more severely affected patients."

The Lightning Process is secretive about its methods, lacks overall medical supervision, and has a cultish quality because many of the therapists are former sufferers who deliver the programme with great conviction. Some children who do not benefit have said that they feel blamed for the failure.

There are overlaps between the Lightning Process and conventional cognitive behavioural therapy, which has been shown to help people with CFS. The process, however, is delivered intensively over three consecutive days, as opposed to 12 or more weeks, and claims to be based on physiological processes that are triggered by stress and can be countered by learning other responses.

Nigel Hawkes, London

Cite this as: *BMJ* 2017;358:j4372

RECRUITMENT was difficult and of 316 possible children only 100 were recruited

THE BIG PICTURE

Lifesaving graphic design

Can graphic design save your life? This is the question posed in a new exhibition at the Wellcome Collection in London, which features an array of images showing how graphic design influences our everyday health.

From packaging that instructs us which pill to take to awareness campaigns that stop the spread of infectious disease, the exhibition explores the power of graphic design and its communication methods.

Stephen Doe painted this mural during the Ebola outbreak in west Africa in 2014. He was trying to communicate with a population with poor literacy and in which more than 30 languages were spoken. He painted the wall red, a colour associated with danger, and used few words alongside graphic illustrations.

Can Graphic Design Save Your Life? is at the Wellcome Collection, London, from 7 September to 14 January 2018. https://wellcomecollection.org/graphicdesign.

Anne Gulland, London

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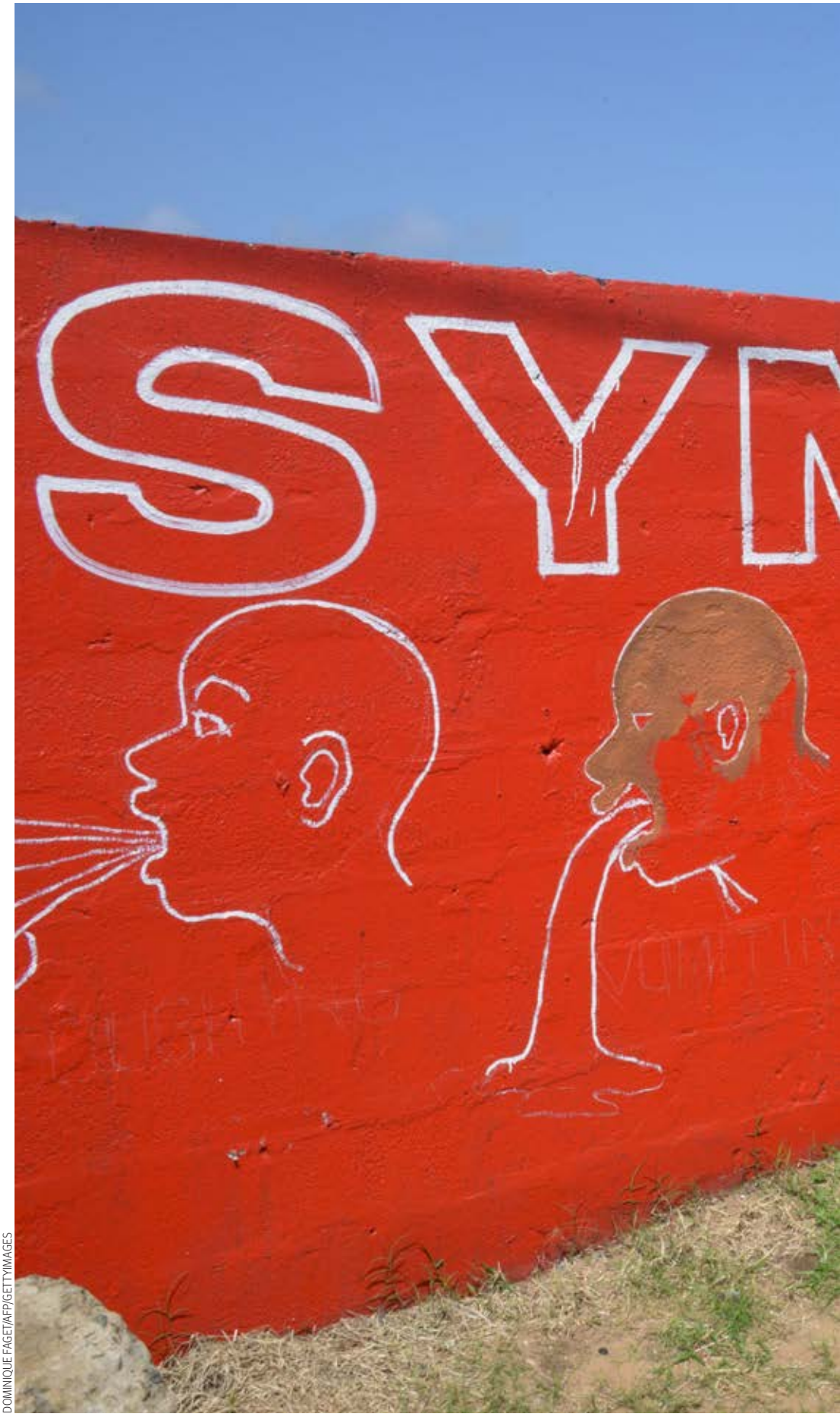

DOMINIQUE FAGET/AFP/GETTYIMAGES


MPTOMS OF EBO
ARRHEA
MUSCULAR PAINS
RED EYES

EDITORIAL

A smoke-free generation?

Unlikely, thanks to complacency, naivety, and impotence in the face of big tobacco

In 1854, John Snow carried out a study of the Broad Street cholera epidemic that is now recognised as a classic of epidemiology and public health practice.[1] In the same year, Philip Morris made his first cigarette.[2] Today, cholera still occurs but is rare, while cigarettes represent the biggest preventable threat to global health.

The magnitude of that threat is laid out in the latest World Health Organization report on the global tobacco epidemic.[3] The report estimates that tobacco use currently causes around seven million (or one in 10) global deaths each year and details progress implementing the six core tobacco control policies advocated under the MPOWER acronym (Monitor, Protect from smoke, Offer help to quit, Warn about dangers, Enforce bans, and Raise taxes).[4] These policies are intended to discourage people from consuming tobacco, much as removing the handle of the Broad Street pump reduced access to contaminated drinking water,[1] but despite the upbeat tone of the report it is clear that progress is slow.

Although 62% of countries fully implementing one MPOWER policy and 37% two policies[3] is clearly an achievement, the corollary is that nearly 40% of countries have yet to implement even one of them, let alone all six. Furthermore, implementation achieves little if policies are not observed and, where necessary, enforced. According to WHO, compliance with MPOWER is often insufficient.[3]

There are many reasons why countries, rich or poor, fail to take adequate measures to prevent smoking. In the early stages of tobacco use in any country there is little sign of harm, since the epidemic of tobacco deaths lags smoking uptake by about three decades.[5] At this point, therefore, tobacco generates tax revenues and employment, creating wealth today while the health costs remain comfortably far in the future.

Cigarettes represent the biggest preventable threat to global health

Industry driven

The smoking epidemic is driven by a rich and powerful industry with the resources to beguile, deceive, and exploit governments of countries at all levels of development. At times a generous benefactor that funds mobile libraries or digs community wells, at others litigious and bullying, this is an industry that has stopped at nothing in the pursuit of profit. Today, Philip Morris International declares publicly that it seeks to replace cigarettes with less harmful alternatives,[6] yet only last year it was undermining tobacco control policies in India in order to sell its Marlboro cigarettes.[7]

The high standards of corporate behaviour trumpeted by British American Tobacco online[8] contrast with the tactics reported to be used by the company to undermine tobacco policies in African countries.[9 10] Like the slave traders of the 18th century, the transnational tobacco companies are powerful, wealthy, part of the establishment, and a stain on our societies.

Even in a wealthy democracy such as the UK, the government response to the tobacco epidemic and the industry behind it is inadequate. The new tobacco control plan for England, published in July 2017 after long delays, talks of achieving a smoke-free generation but defines smoke-free as a prevalence of 5% or less.[11] At 5% prevalence there will still be over two million people in England, predominantly disadvantaged and in many cases mentally ill, who smoke; this is fewer than today perhaps, but hardly smoke-free.

The targets for reducing prevalence in the plan are far from challenging. The lack of ambition in these targets perhaps accounts for the lack of definition in and financial backing for the measures contained in the plan: after all, just carrying on as we are should deliver the targets on time. Measures designed to strike at the industry driving the epidemic, such as a "polluter pays" levy on tobacco, are absent.

The WHO report and the English tobacco control plan thus show two of the main difficulties faced by people who would like to see cigarettes eradicated quickly: the relative impotence of international agencies and impecunious governments in the face of powerful multinational industries, and the complacency of governments in rich countries, which are content to observe rather than accelerate declining tobacco use and wary of challenging profitable industries. Smoking kills, but while people are making money out of it, it seems that is the price that the rest of society must pay.

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EDITORIAL

Future of screening for prostate cancer

Multiparametric magnetic resonance imaging is likely to be part of it

Current best evidence suggests that prostate specific antigen (PSA) testing provides only a small reduction in prostate cancer mortality and no reduction in all cause mortality, while at the same time exposing healthy individuals to the risk of overdiagnosis and overtreatment.[2]

Better tests

Meanwhile, developments are under way that may allow us to improve diagnostic accuracy and potentially lessen the burden of testing and treatment associated with prostate cancer screening. Tools such as the Prostate Health Index and the 4Kscore, which calculate risk from measurements of multiple biomarkers, may enable better risk stratification for men who choose screening, although no evidence based guidelines currently endorse their routine use.

Perhaps more promising in the short term is the development of multiparametric magnetic resonance imaging (mpMRI), which combines morphological assessment of the prostate with elements of functional and physiological assessment. There has also been a concerted, multiorganisational effort to standardise the acquisition, interpretation, and reporting of mpMRI in the form of the Prostate Imaging Reporting and Data System (PIRADS).[5]

PROMIS study

The most notable study so far to place mpMRI on the map as a potential tool for identifying men with clinically important prostate cancer is PROMIS.[6] This prospective cohort study from the UK enrolled 740 screened men with PSA concentrations up to 15 ng/mL and scheduled for their first prostate biopsy. The authors compared the diagnostic accuracy of mpMRI with traditional transrectal ultrasound (TRUS) guided biopsy, by testing them both against a reference standard test—template prostate mapping (TPM) biopsy, which samples tissue every 5 mm through the prostate.

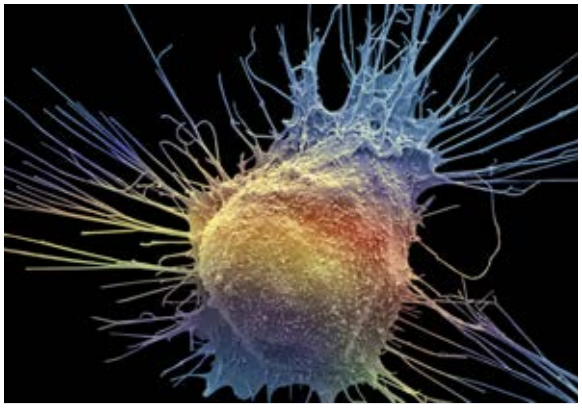
A total of 576 patients completed all three tests. The primary outcome was clinically significant cancer defined as a Gleason score ≥4+3 or a maximum cancer length in any biopsy core ≥6 mm.

Based on the reference standard biopsy, 230 men (40%) had clinically significant prostate cancer and an additional 178 men (31%) had clinically insignificant cancers. The sensitivity and specificity of mpMRI for identifying the primary outcome were 93% (95% confidence interval 88% to 96%) and 41% (36% to 46%), respectively, compared with 48% (42% to 55%) and 96% (94% to 98%), respectively, for TRUS biopsy.

Using the prevalence found in the study, the 27% of men with a negative mpMRI result would be able to avoid a biopsy, accepting a 11% probability of a false negative MRI result. Patients with suspicious MRI findings would have a roughly 50% chance of having clinically significant prostate cancer.

Reducing the need for prostate biopsy is a major step forward that will be welcomed by all men

Reducing the need for prostate biopsy is a major step forward that will be welcomed by all men, and especially those who have had the procedure. One source of bias in this study relates to the relatively large proportion of enrolled patients (22%) who did not complete the study, most commonly because their prostate was too large for a TPM biopsy (>100 cm^3). Secondly, interpretation of mpMRI is known to be subject to major interobserver variability.[7] Unless rigorous training and quality assurance is implemented, centres adopting mpMRI are unlikely to match the diagnostic accuracy reported by these experienced investigators. Lastly, mpMRI was not used to identify men for TRUS biopsy in this study. The results therefore provide only indirect evidence about how MRI imaging would perform when used as a triage test in the diagnostic pathway.



The study authors should therefore be congratulated for taking the critical next step and conducting a randomised controlled trial of mpMRI triage. The PRECISION (Prostate Evaluation for Clinically Important Disease: Sampling Use Image-Guidance or Not) trial is in the process of randomising 470 men to mpMRI triage versus standard 12 core TRUS biopsy.[8] In the former group, a prostate biopsy is performed only after a suspicious mpMRI, which is then used to target the biopsy. The primary endpoint is once again clinically significant prostate cancer.

Men at risk of prostate cancer, their families, and the health professionals who care for them should all be encouraged by the development of mpMRA and the rigorous evidence based approach being taken to evaluate new screening strategies. While not solving all current problems, both hold much promise for the future of prostate cancer screening.

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EDITORIAL

Implementing person centred approaches

Education and training of the workforce is crucial, as is the policy framework that influences behaviours

Political and policy declarations now widely acknowledge that the individual should be at the heart of the health system.[1-3]

However, although there is widespread agreement that person centredness is important, the concept itself remains subject to debate. Studies exploring understanding of self management—a core component of a person centred approach [6]—have shown that many outcomes important to people receiving care are rarely mentioned by health professionals.

Even where overlaps occur, outcomes are interpreted differently. For example, knowledge is regarded as important, but health professionals tend to view this as knowledge about the disease process ("knowing that"), whereas people receiving care emphasise knowledge that is personally relevant and tailored to their specific situation ("knowing how").[8] People place particular value on the quality of their relationship with their healthcare professional, but this understanding is not commonly expressed by providers.[9]

New framework

This apparent disconnect between people's and health professionals' views and interpretations about what constitutes person centredness highlights a need to adapt the training of health and care professionals to enable them to engage in a true partnership with people receiving care. The person centred care framework, published in July 2017 by Health Education England, Skills for Health, and Skills for Care,[10] is therefore welcome.

The framework places communication and relationship building skills at the centre of all interactions, setting out the necessary underlying values and behaviours, describing desirable (what people receiving care and their carers want to see) and undesirable practices along with the expected learning outcomes from education and training for staff.

Person centredness is important, the concept itself remains subject to debate

Importantly, the framework recognises that simply developing new skills and knowledge will not be enough to achieve fully person centred health systems. Professionals also need a supportive culture within organisations that encourages and fosters long term behaviour change.

The framework considers how systems can enable the embedding of person centred communication and support into daily practice. This is crucial, given that much of the available literature focuses on personal interactions between the care provider and the individual receiving care and neglects the organisational and system contexts.[11] The framework lists those involved—from system and organisation leaders to commissioners of services and of education and training providers—and asks "challenge questions" to encourage reflection about the understanding, adoption, and further embedding of person centredness in their respective areas of responsibility. Here it draws heavily on the behavioural change approach, which has shown promise in improving the design and implementation of evidence based practice. Yet, effective behaviour change depends on an understanding of the determinants of current and desired behaviours.[12]

Who is responsible?

The framework is not specific about who should be accountable for taking the recommendations forward. Implementing person centred care and systems will perhaps inevitably create tensions between various stakeholders.

Tensions may also arise where national priorities are not aligned and other, potentially competing goals dominate local priorities for service delivery. This has been seen with the implementation of support strategies for self management in England—measurement and payment remains linked to biomedical outcomes rather than incentivising working with people and outcomes that matter to users of healthcare, taking full account of their wider social context.[14 15]

Managers need to consider how to best support their staff in implementing person centred healthcare. This will entail making relevant person centred activities a priority, despite demands placed on organisations by the wider system contexts, including limited resources. Furthermore, decision makers must be alert to the potential tensions and unintended consequences of policies that are not consistent and that hinder rather than enable the implementation of person centred approaches. We need to create a policy environment that provides those charged with implementing change with the means, capacity, and competence to do so.

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The mixed messages on vaping that caused an e-cigarette shambles

Journalists had fun with conflicting information on the safety of vaping, writes **Nigel Hawkes**, but behind the reporting were some interesting new data

To vape or not to vape: that is the question. It divides public health specialists, some of whom favour electronic cigarettes to aid smoking cessation and some of whom do not. Feelings on both sides run strong.

There's much need, then, to tread carefully. So when Public Health England decided to include e-cigarettes in its annual "Stoptober" smoking cessation television advertisements for the first time this year, it might have been wise to ensure that no other government body was poised with advice that could conflict.

Alas, "the grid"—a government schedule of announcements developed in the Tony Blair years and designed to avoid clashes of just this kind—seems to have failed. Public Health England's announcement emerged within 24 hours of draft guidance from the National Institute for Health and Care Excellence (NICE) advising GPs to tell patients that e-cigarettes are unlicensed for smoking cessation and that there was little evidence of long term benefits or harms.

Much safer than smoking

To confuse matters further, the Scottish government on the same day published a document signed by 20 experts, including Scotland's chief medical officer, Catherine Calderwood, saying that vaping was much safer than smoking. This message was diluted by yet another report, this one from California, beyond the reach of any grid, saying that vaping causes a spike in adrenaline that could cause heart attacks.

Journalists are drawn to conflict, and the headlines reflected it. "E-cigarette shambles," said the *Daily Mail*. "The great e-vape," was the *Daily Record*'s take. "Vapes of wrath," said the *Sun*, and a sidebar was headlined "Vaping bad."

So, plenty of fun was had all round—but a textbook example of how best to present public health advice it was not.

NICE has since denied any substantial difference with Public Health England. Its deputy chief executive Gillian Leng insisted, "Stoptober advice is completely in line with the NICE draft guidance. These are new products, and naturally results of long term studies are only now emerging—reinforcing the view that e-cigarettes carry a fraction of the risk of smoking. Our recommendation is that people should receive advice on e-cigarettes so that they can make informed decisions on how to stop smoking."

In support of its advice Public Health England cited a study by Jamie Brown and Robert West of University College London comparing smoking cessation rates between 2007 and 2017 with those in the first half of 2017. It found that current quit rates (defined as having stopped in the previous year and still not smoking at the time of survey) were at a record high.

Poorer people improve most

The authors found that the quit rate in the first six months of 2017 was 33% higher (95% confidence interval 9% to 62%) than the average for the previous 10 years. A striking finding was that lower socioeconomic groups accounted for all the improvement.

"E-cigarette shambles," said the *Daily Mail*. "The great e-vape," was the *Daily Record*'s take. "Vapes of wrath," said the *Sun*, and a sidebar was headlined "Vaping bad"

Previous work has shown that all socioeconomic groups are equally keen to give up but that in the past poorer groups had done so less successfully than better-off people.

"The improvement has resulted in parity between the groups in quit success rates for the first time in over 10 years and possibly ever," the authors reported in *Smoking in Britain*, a peer reviewed journal that includes Brown on its editorial board. The improvement in the quit rate cannot be attributed to e-cigarettes, because quitters were not asked what technique they used.

In the Stoptober press release, however, Public Health England said that e-cigarettes were "one of the key drivers" of the higher quitting success. "If you've struggled with quitting before, e-cigarettes may be the best option for you," says John Newton, the agency's director of health improvement. However, England's deputy chief medical officer, Gina Radford, didn't mention e-cigarettes at all in her endorsement of Stoptober. A careful woman, clearly.

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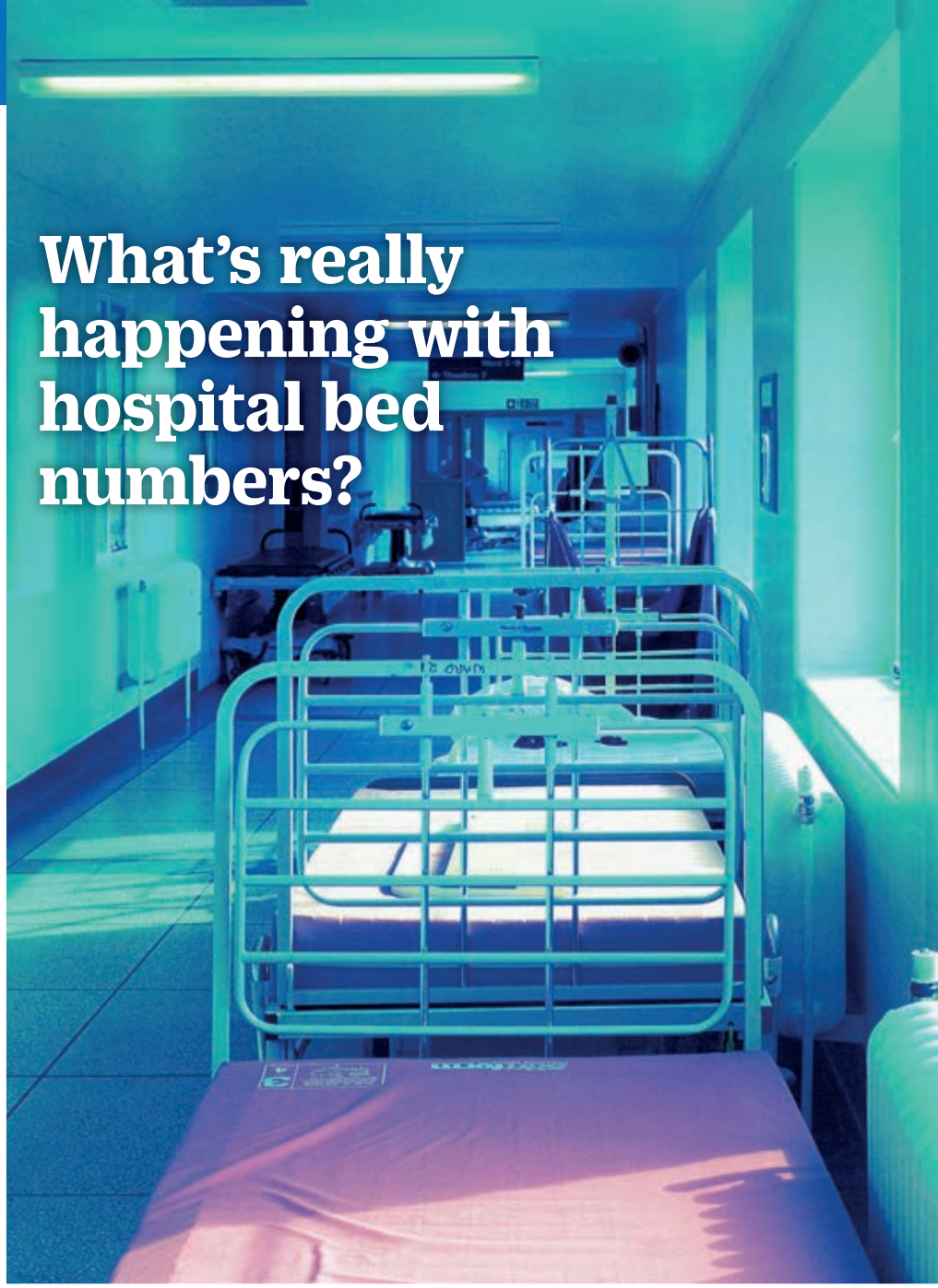
DATA

What's really happening with hospital bed numbers?



Doctors warn that hospitals are "reaching breaking point" in response to a report that seeks to provide a better understanding of NHS bed capacity in England, writes **Jennifer Richardson**

"It feels really tough on the wards," says Royal College of Physicians registrar Andrew Goddard. A report from the King's Fund this week confirms one reason why: hospitals in England are at risk of being unable to manage the movement of patients between departments, because of a growing shortage of beds.

It is the conclusion of an analysis of NHS hospital bed figures over the past 30 years. Drawing on multiple sources of data, *NHS Hospital Bed Numbers: Then, Now, Next* attempts to paint a clearer picture of the national situation.

This is particularly pertinent given the sustainability and transformation partnerships (STPs) charged with overhauling care by 2020-21—as the report points out, half of the 44 STPs propose to reduce the numbers of acute beds or close emergency departments.

The number of NHS hospital beds in England has more than halved in the past three decades, the report estimates. However, it emphasises the difficulty of establishing firm figures, thanks to differing methods of data collection; the report says that "staffed beds is generally what is meant." The numbers cover general and acute, mental health, learning disability, maternity, and day only beds, as averages of "beds available [each day] for patients to receive care that are in NHS providers." The report urges NHS England to provide a "transparent, accurate, and comprehensive picture of bed capacity" through a national audit.

The King's Fund points out that reduction in bed capacity is more significant than the absolute numbers suggest; population growth means beds per capita have fallen faster than absolute numbers. For acute beds across the UK, beds per capita are less than two thirds the average for the 15 pre-2004 EU countries. The true picture is likely to be even greater pressure on beds in England, the report says, thanks to an increasingly older population who are more likely to need them.

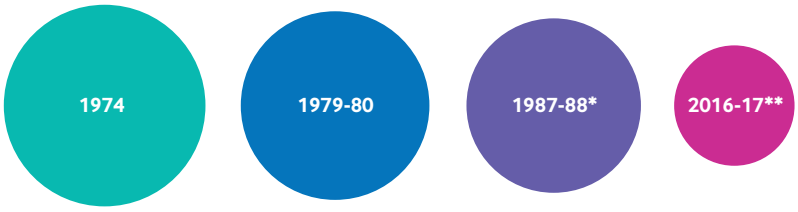
Exactly how many beds are needed is also far from clear. Because of the number of contributing factors—including demographics and workforce—the optimum number changes over time and location, the report says. Fewer beds do not necessarily mean a shortage, but the authors point to "extremely high levels of bed occupancy and stubbornly large numbers of delayed transfers of care" as indicators that this is increasingly the case. The report also

"The hospital seems to be full once a week"

Andrew Goddard, registrar, Royal College of Physicians, and consultant gastroenterologist, Royal Derby Hospital

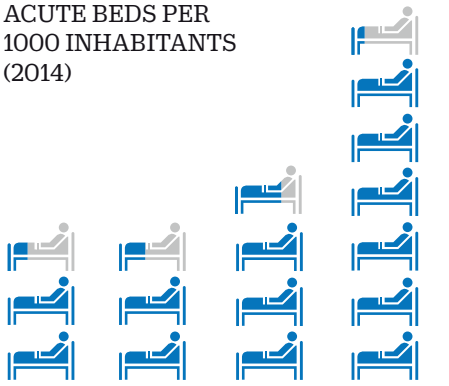
In the 15 years I've been a consultant physician, bed numbers have reduced by 25% and emergency admissions increased by 51%. We've got the average length of stay down by 36% —but it is getting harder. Ward rounds have gone from twice weekly to daily with seven day working; this has improved flow. It may also have damaged training. I've seen the specialties of acute medicine and ambulatory care introduced—both great. Delayed discharges seem increasingly common, though, and the hospital seems to be full at least once a week, most weeks. Many local community hospitals have been sold off, which I'm sure hasn't helped. In short, it feels really tough on the wards and—while I'm lucky to have fantastic colleagues who all muck in to get through the frequent bed crises—I do wonder if there is much juice left in the NHS bed orange to squeeze."

NUMBER OF NHS HOSPITAL BEDS IN ENGLAND



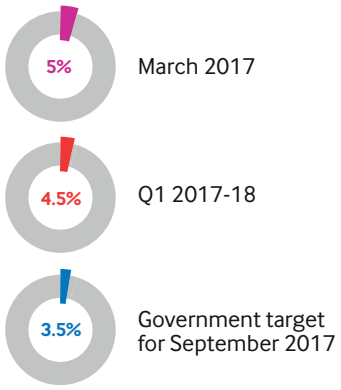
Average numbers available each day
*annual figures **unweighted averages of quarterly figures

ACUTE BEDS PER 1000 INHABITANTS (2014)



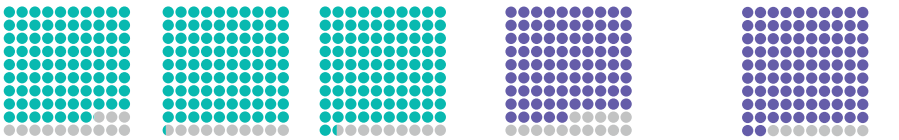
*EU member states prior to the May 2004 expansion: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, UK

BEDS USED BY PATIENTS WHO COULD HAVE BEEN DISCHARGED



Source throughout: *NHS hospital bed numbers: then, now, next*, King's Fund September 2017

BED OCCUPANCY RATE*



*Overnight for acute and general beds, unweighted averages of quarterly figures

highlights a 58% increase in NHS spending on private bed providers between 2015-16 (£241m) and 2016-17 (£381m).

One of the rationales for bed cuts is more care in the community—however, the report finds non-hospital services insufficient to meet need. "Intermediate care capacity is currently only enough to meet around half of demand," it says.

Despite this, the King's Fund identifies slack still to be tightened. This includes geographical variation in length of stay: if all hospitals could match the shortest, bed capacity (and money) could be saved. The report highlights several promising examples of initiatives to make better use of existing beds, including a care home initiative that reduced emergency department attendances and emergency admissions.

However, the authors say that there is a lack of time and money to allow development of new models of care to reduce demand. In addition, the report suggests that a slowing down in the reduction of bed numbers shows that much of the fat has already been cut—so further reduction is likely to be increasingly difficult. Yet some STPs propose increasing the rate of cuts.

These plans look unachievable, the King's Fund says. Instead, "realism" is needed—and a more attainable target may be to manage increases in demand for hospital services without increasing the number of beds.

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John Kell, head of policy, Patients Association

"Patients are kept for too long in hospital beds"

This report shows that, in some ways, the NHS's ability to use its beds ever more intensively has been a success—but it can't produce benefits exponentially.

It is clear that we are not good enough at keeping and getting people out of hospital. The solutions often go hand in hand with improving patient experiences: timely joint replacement surgery reduces demand on hospitals precisely because it achieves better outcomes for patients.

Under-resourcing of care for people in their own homes is implicated heavily. Without this, too many patients will be kept for too long in hospital beds.

The evidence presented here casts further doubt on the viability of some STPs to reduce hospital bed capacity significantly—and, unfortunately, for some that is key to the "sustainability" aspect of their plans. We need to move away from the assumption that service transformation means significantly reducing acute capacity, and instead think about it in terms of improving patient experiences and outcomes—and avoiding a steep climb in demand for acute care.

Nigel Lane, consultant in acute medicine, North Bristol NHS Trust

"We are caring for patients in corridors"

This report highlights what we have all been feeling on the frontline for the past few years: patients are becoming older and frailer; attendances are going up; length of stay has decreased but feels like it is plateauing for acute medical admissions; and delays in transfers of care have increased. Coupled with this is the halving of the number of NHS hospital beds in England in the past 30 years.

This has resulted in caring for patients in corridors, clinical risk taking with acute discharges, and a feeling of impending doom among frontline staff.

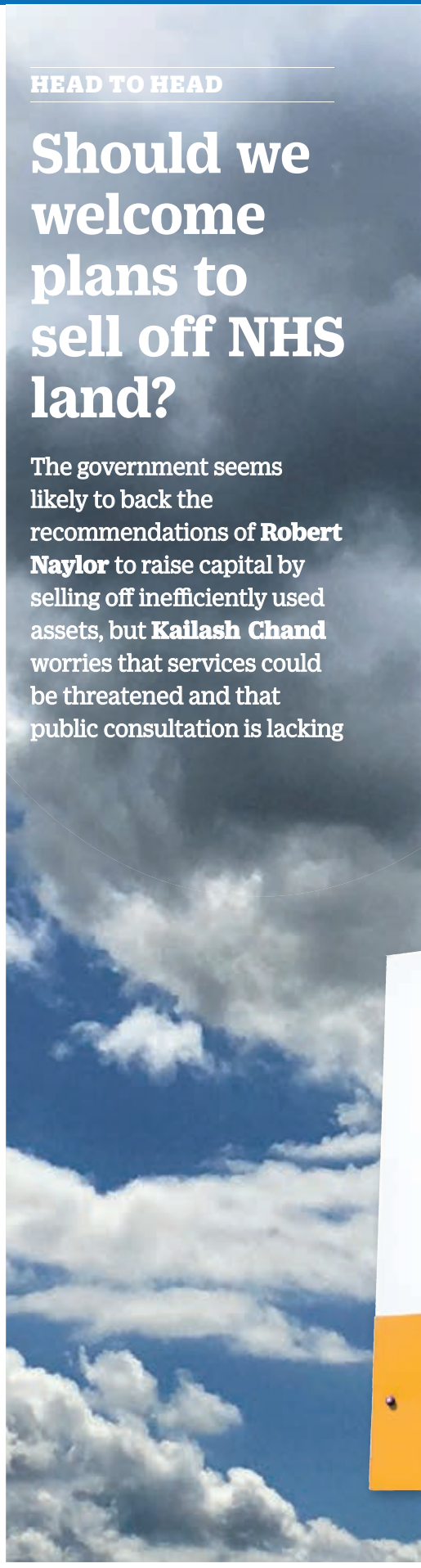
These reductions in overall bed numbers and increase in occupancy rates are having a real impact on my team and the patients we see. While we will continue to try to expand the numbers of patients we see in ambulatory care, and avail ourselves of opportunities to reduce variations in care—the current feeling is that we are reaching breaking point.

As the report points out, every acute bed is "staffed"—and the staff can only achieve so much with the resources we have.

HEAD TO HEAD

Should we welcome plans to sell off NHS land?

The government seems likely to back the recommendations of Robert Naylor to raise capital by selling off inefficiently used assets, but Kailash Chand worries that services could be threatened and that public consultation is lacking



yes

The NHS estate is not configured to maximise benefits for patients or taxpayers. New buildings are required to maximise value

Robert Naylor, national adviser on NHS property and estates, Manchester robertanaylor@hotmail.com

The Organisation for Economic Co-operation and Development rates the NHS as the most cost effective health system in the world, but with more than £5bn of backlog maintenance the quality of our buildings and equipment leaves much to be desired. Our doctors and nurses—and particularly our patients—deserve better.

The 1962 Hospital Plan for England created the hospital system we have today, but the NHS has failed to modernise—18% of buildings predate the NHS itself. Last year's Carter Report evidenced poor management and unacceptable variations in estate costs. It recommended that hospitals have strategic plans to create modern healthcare facilities. In response, the government commissioned me to carry out the Naylor Review, to develop a strategy to identify unused or underused estate, with specific targets to release £2bn and to deliver land for 26 000 new homes.

The review concludes that the disposal value of wasted estate could be as high as £5.7bn and the new homes target delivered in the London region alone. These "affordable" homes should be prioritised for NHS staff in high cost residential areas to tackle escalating staff shortages. Local decisions should determine if land should be sold, leased for development, or developed by the NHS itself.

Additionally, the disposal of this estate would boost local economies and save the NHS £1bn every year. These funds, together with Treasury and private sector funding, to a total of £10bn, should be fully reinvested in the NHS to deliver a modern estate.

KEY RECOMMENDATIONS

- STPs need about £10bn, from property disposal, private capital, and government
- STPs should develop affordable estates plans
- Providers with inadequate plans should not be granted capital funding
- Capital from the sale of locally owned assets should benefit local services
- Government should provide financial incentives to match land disposals
- Payments in primary care could be linked to quality of facilities
- Sold land should be prioritised for homes for NHS staff where needed

This is absolutely not privatisation nor "fire sale" but a reinvestment of wasted assets to improve patient care.

Following extensive engagement with stakeholders and key experts, including a King's Fund evidence review and detailed modelling by Deloitte, the review conservatively estimates a need for £10bn additional capital funding—£5bn for backlog maintenance, with a similar sum needed to deliver the *Five Year Forward View*.

Without investment, the *Five Year Forward View* cannot be delivered and the NHS estate will continue to deteriorate. Estate plans must meet patient needs developed through local sustainability and transformation partnerships (STPs), focused on keeping people healthy by investing in primary and community care.

The NHS estate is not configured to maximise benefits for patients or taxpayers. Significant service reconfigurations and new buildings are required to maximise value, led by STPs, with public support, engagement, and consultation through STP plans.

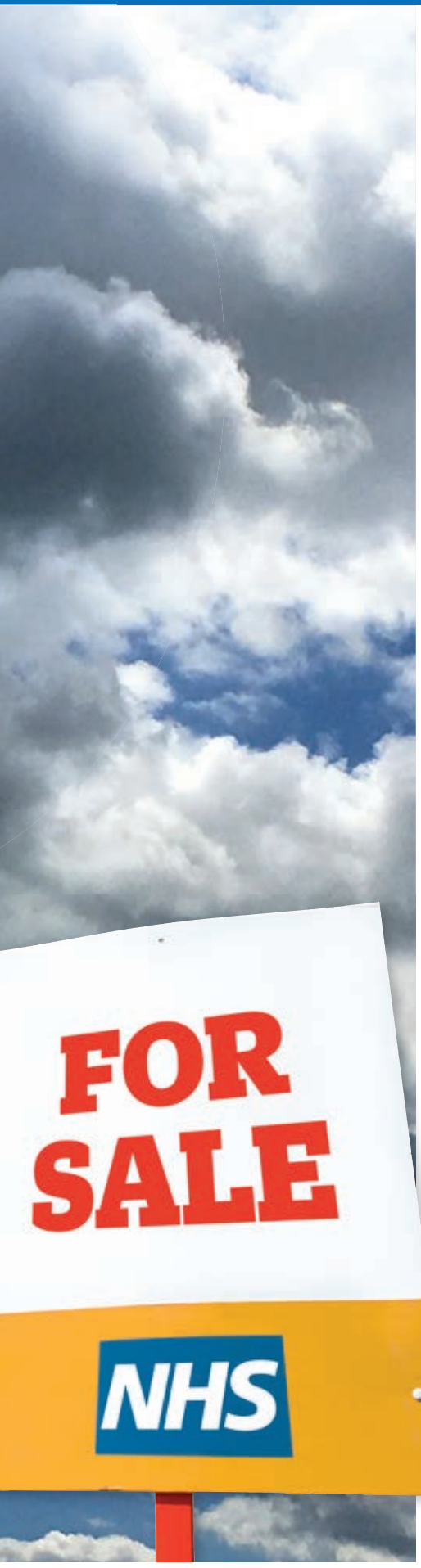
Investment in buildings

Although the government has yet to respond formally to the review, the Conservative Party's manifesto recognised the urgency, stating, "Since its inception, the NHS has been forced to use too many inadequate and antiquated facilities." During the next parliament the Conservatives plan "the most ambitious programme of investment in buildings and technology the NHS has ever seen."

The prime minister, Theresa May, later clarified that she supported the Naylor Review and that investment would achieve the recommended figure of £10bn.

So, the evidence is clear, the strategy agreed, and all we need is implementation. And it's here that strategy is most likely to fail. Swift action is needed to accelerate change and build momentum. Change will always be controversial and politicians, supported by robust STP plans, must assume responsibility for oversight and scrutiny.

Finally, as someone who has dedicated my working life to the NHS, I consider this a generational opportunity to sustain a fit for purpose, cost effective NHS estate, which can only be good news for patients and allow the NHS to remain the envy of the world.



no

Any debate about whether premises are "surplus to requirements" should include patients, clinicians, and the public

Kailash Chand, GP, Manchester kchand@btconnect.com

When Robert Naylor published his report in March, examining how the English NHS could raise cash from its premises, he stressed that it needed "substantial capital investment"—an extra £10bn. He accepts that the NHS is at breaking point and, to keep promises made to patients and staff, investment must be made.

Three years into the *Five Year Forward View* facilities lack investment. But as the NHS struggles with deficits and staff shortages, NHS England spends millions on advisers to push through new models of care.

Transparency is crucial

There has been a general lack of understanding among clinicians, patients, and the public about changes to the NHS. STPs are being driven by funding restrictions, not planned provision. Naylor's recommendations require NHS property to be brought into the equation, with financial incentives for those who sell property to push forward their local plans to suit NHS England's hasty timetable. Many trusts and foundation trusts are deep in deficit, and the STPs require the closure of services and the sale of infrastructure that the BMA estimates at £26bn, with financial penalties for failure.

Any debate about whether premises are "surplus to requirements" should include patients, clinicians, and the public. Their sale could affect millions of patients if services are closed or merged as a result. Far from all lying empty, some buildings proposed for sale are in clinical use. Charing Cross Hospital in London, for example, may be reduced to just 14% of its existing area and the rest sold off for development.

The chief executive of NHS Confederation has argued that premises not fit for purpose could be converted into housing so that NHS staff can live in the communities they care for. Private sector developers currently own between them enough land to build about 600 000 new homes. So there is no critical need for the release of any public sector land—except to increase the profitability of, and to get private hands on more, prime property at low prices. And there are no guarantees that the government will follow the specific recommendations in the report to ensure that NHS land sold to developers is used for specific purposes.

It is in London that Naylor thinks he'll find most of the properties that will provide the billions he is expecting, some 60% of the cash, in fact. The reality for investors looking at development properties is that central London hospitals occupy valuable sites; long derelict, small town general practice surgeries do not. Naylor's review confirms this as key to changing the estate to meet the new models of care. He has a second report on London estates, unpublished for reasons of "commercial confidentiality." There could be no better illustration than this of the question of transparency and accountability around land disposals.

More broadly, we should discuss why patients and doctors don't have the properly funded health service they deserve—with care, not cost cutting, at its core. This is the debate we need to have but it is not happening. The concern is that the government has indicated that it is prepared to plough on without the public or patients' understanding or involvement.

It may make sense to reinvest unused assets in health services, but we need urgently to take an honest look at the pressures facing the NHS, and we need guarantees that any plans to transform care are evidence based and open to scrutiny. Anything less is unacceptable.

The bigger picture

Pressure to sell off NHS land and buildings, with new investors being sought to provide new sources of capital and debt financing for the NHS, potentially accelerating closures of services, represents more of the costly problems we already face from the private finance initiative and NHS Property Services Ltd, the "PropCo." In 2014 the National Audit Office questioned why the government had failed to consider public ownership for PropCo.

We should take PropCo as a warning. Once government implements recommendations they are difficult to undo. The NAO's report on PropCo changed nothing. Doctors and patients should stand firm before changes are made and demand that there is transparency, accountability, and a thorough evidence based assessment made of public service options to this proposed dispersal of public assets into private hands.

Competing interests: See bmj.com.
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ANALYSIS, p 490

Listen to the authors debate the issue in the podcast on bmj.com

BMJ.COM HIGHLIGHTS

Mental health campaigns and cash strapped services

In a *The BMJ* interview last week, psychiatrist Simon Wessely identified a mismatch between government efforts to increase public awareness about mental health, and its under-resourcing of services to meet this demand. His comments split opinion among readers.

"Every time we have a mental health awareness week my spirits sink," said Wessely, explaining that "we don't need people to be more aware. We can't deal with the ones who already are aware . . . I'm really worried that we will overstretch and demoralise our mental health services if all we do is raise awareness but don't provide more people . . . [and] better support." Here are some of the mixed reactions on Twitter:

Despite all the awareness we are still desperately short of resources. PR does not keep the lights on or keep units open
David @PsychDrD

Sad paradox: Mental health awareness is harmful when mental health is so badly funded. Distracts attention/ resources from those most in need
Allen Frances
@AllenFrancesMD

Totally agree. If anything, awareness raising days are just going to make many angry at the services which are under-resourced
Richard Graham
@rgraham120

The focus should be on increasing services, not negating experiences
Laura M C @lauramidcur

We can't reverse on #mentalhealth awareness in order to reduce demand on an underfunded (and in #primarycare) badly resourced service
RoslynByfieldTherapy
@RoslynByfield

Public awareness campaigns need to be balanced with adequate resources, but early intervention is cost effective in the long run
Lexie Thorpe @Lexie_Thorpe

We've made great gains in raising awareness [of] #mentalhealth. It's the system that must change
Dr Andy Mayers FRSA
@DrAndyMayers

MOST READ ONLINE

Simon Wessely: "Every time we have a mental health awareness week my spirits sink"
BMJ 2017;358:j4305

Men over 40 are most at risk of sudden death during triathlons
BMJ 2017;358:j4326

Corticosteroids for sore throat: a clinical practice guideline
BMJ 2017;358:j4090

Beating type 2 diabetes into remission
BMJ 2017;358:j4030

FROM THE ARCHIVE

Peace for our time?

On this day in 1938, the Munich Agreement was signed, permitting Nazi Germany's annexation of parts of Czechoslovakia, yet avoiding escalation of the dispute to war. The prime minister, Neville Chamberlain, reassured the British people that "I believe it is peace for our time . . . Go home and get a nice quiet sleep," yet the pages of *The BMJ* in the following weeks reveal a country still uneasily readying itself for war.

In the 8 October issue, the journal reported (*Br Med J* 1938;2:S233) how the BMA, at the request of the government, had compiled a "War Emergency Register" of doctors who would be able to serve. "Today any immediate danger of war is a thing of the past," reads the report, while noting that there can be "no guarantee that a similar emergency may not again arise."

Elsewhere in that issue (*Br Med J* 1938;2:749) is a call for the government to "seek the assistance of the best brains in the medical profession" when drawing up "arrangements for coping with casualties from air raids." "If there is unhappily to be another war, London will be the front line," predicted the journal, observing that this will affect "millions of its inhabitants and a considerable fraction of the medical profession."

Chamberlain claims to have secured peace

The day after the agreement was signed, the 1 October issue (*Br Med J* 1938;2:710) had this prescient message for doctors: "Once again—and within twenty five years—the members of the medical profession have had to share with all thoughtful fellow citizens the anxiety of a worsening international situation and a menace of general European war . . . With the causes of the crisis medical men and women as such are not directly concerned, save to deplore racial animosities that lie at the root of the trouble . . . During these past weeks and days of growing apprehension doctors have gone about their daily tasks and steadied the nerve of others. If crisis should lead to catastrophe—and at the time of writing the issue of peace or war is still in the balance—they will continue at their accustomed duties."