GPs threaten patients over flu vaccine

**EXCLUSIVE:** GPs are being warned not to let their push to deliver flu vaccinations this winter spill into “bad behaviour,” after a practice was reported to commissioners for threatening to withhold repeat prescriptions unless patients chose to be vaccinated there.

The unnamed practice was reported to NHS England and Doncaster CCG by pharmacists who also offer the vaccination. The threat was subsequently withdrawn.

Doncaster Local Pharmaceutical Committee (DLPC) and the town’s medical committee said that tension between GPs and community pharmacists had risen since 2015 when the government allowed pharmacists to administer flu vaccinations to vulnerable adult patients. Both are paid £7.64 for each patient they vaccinate.

The committees urged the two groups to work cooperatively rather than against each other to increase uptake across the board.

Dean Eggitt, a GP and medical secretary of Doncaster Local Medical Committee, told The BMJ, “This is all about cash. This looks to be a one-off rogue case, but it’s a symptom of a problem on a much grander scale. We will see more tensions unless we figure out how to work better together.”

Eggitt said that, in addition to the potential loss of the £7.64 per vaccination, practices lost money if they had to return unused stock and, if pharmacists failed to tell practices which patients they had vaccinated, GPs could not claim payments under the Quality and Outcomes Framework (QOF) incentive scheme.

“For some practices this is about viability—it’s about life or death. The only way to [improve] this is to increase the actual baseline funding that goes into practices, so that we stop chasing these pennies and start worrying about care”, said Eggitt.

Nick Hunter, chief officer of DLPC, told The BMJ, “I fully understand that GPs feel threatened by pharmacies doing flu vaccination. But patients like it. This is also a way of relieving some of the pressure on general practice, but the financial flows have to go with where the work is done.”

Hunter said the committees and commissioners would be issuing a joint statement to emphasise the importance of collaboration. “If we can work together, we’ll all do more flu vaccines and we’ll all be better off, and the population will be better off,” he said.

A spokesperson for the CCG confirmed it had spoken to the practice about its conduct, adding, “The matter has been settled amicably.”

**Cite this as:** BMJ 2017;359:j4682

**LATEST ONLINE**
- GPs think the complexity of primary care is a barrier to physician associates
- Junior doctor is struck off after trying to arrange sex with minor
- High Court will hear class action against metal-on-metal hip manufacturer
Junk food ads outspend state’s healthy food campaigns

The government is being urged to take steps to restrict advertising of junk food after a new analysis showed that food companies spend much more on such advertising than the government spends on promoting healthy eating.

The concerns have been raised by the Obesity Health Alliance of more than 40 leading health charities, medical royal colleges, and campaign groups, which released details of the analysis last week.

The analysis used data from *The Grocer* magazine’s top 100 list of advertising spending on fast moving consumer brands, which identifies brands commonly associated with crisps, confectionery, and sugary drinks. The analysis showed that companies producing the top 18 UK brands spent more than £143m on advertising their products last year.

This was around 27.5 times the £5.2m annual spending on the government’s flagship healthy eating campaign Change4Life. In addition, the NHS was spending an estimated £38m a year on weight loss surgery, said the alliance, and treating obesity related conditions cost the NHS around £5.1bn a year.

Adrian O’Dowd, London  Cite this as: BMJ 2017;359:j4677

Assisted dying

Man with advanced MND loses challenge

Noel Conway (below), 67, who has advanced motor neurone disease, lost his challenge to the legal ban on assisted suicide in England and Wales. He argued that the law condemned him to “unimaginable suffering.” Conway asked the High Court in London for a declaration that the ban was incompatible with his human rights. But the three judges ruled that, although the ban was incompatible with his private life, this interference was necessary and proportionate to protect vulnerable people. Conway plans to appeal.

Dutch geriatrician faces charges over death

Public prosecutors in the Netherlands launched a criminal investigation into a specialist in elderly care who ended the life of a 74 year old woman with dementia at a nursing home, claiming “serious suspicion” that a criminal offence was committed. This is the first such investigation under the country’s 2002 euthanasia law. The woman was considered no longer competent to consent but had previously signed a living will requesting euthanasia. But a review committee dismissed the living will as “ambiguous and contradictory” and said that euthanasia had gone ahead without due care.

GP crisis

BMA calls for urgent talks with health secretary

Richard Vautrey, chair of the BMA’s general practitioners committee, wrote to England’s health secretary, Jeremy Hunt, calling for an urgent meeting over the pressures on general practice and warning that practices could be forced to close to new patients. The move follows Hunt’s speech at the Conservative conference, which the BMA criticised for offering no solutions to patient demand and staff shortages. Vautrey wrote, “With unprecedented patient demand, a recruitment and retention crisis, huge workforce shortfalls and major premises problems, it is no wonder that GPs are having to consider action such as suspending their patient lists.”

Diabetes

Insulin pumps cut complications

European children with type 1 diabetes (average age 14) who used an insulin pump had considerably lower rates of severe hypoglycaemia (9.55 v 13.97 per 100 patient years), hypoglycaemic coma (2.30 v 2.96 per 100 patient years), and ketoadiposis (3.64 v 4.26 per 100 patient years) than those who had injections, as well as lower glycated haemoglobin levels (9.04% v 8.22%), a JAMA study of nearly 20,000 children found. Figures from NHS Digital show that 15.3% of people with type 1 diabetes were treated with an insulin pump in England in 2015–16.

Compensation

Trust pays £600,000 to 18 boys abused by consultant

Cambridge University Hospitals NHS Trust has paid £611,750 so far to sexual abuse victims of a former paediatric haematologist, a freedom of information request by the BBC found. Myles Bradbury was jailed in December 2014 after admitting to 25 offences against 18 boys at Addenbrooke’s Hospital. The boys had blood cancers, and his offences, committed while examining them, involved touching naked genitalia. The BBC said that the payments related to 15 of the 31 claims the trust had received.

Trainee doctors

Views sought on newly qualified doctors’ skills

The GMC launched a consultation on the knowledge, skills, and professional behaviours needed by newly qualified doctors, which runs until 10 January 2018 (gmc-uk.org/education/31336.asp). The updated Outcomes for Graduates will help develop the medical licensing assessment, which is due to be implemented in 2022 to ensure that UK doctors meet a common threshold.

Campaign calls for rethink on job titles

Doctors and academics in the Oxford Health Alliance called for “discriminatory and belittling” titles such as “junior” and “trainee” to be abandoned in favour of titles that reflect doctors’ seniority and skills. The Department of Health said it would review the use of the titles.
**MEDICINE**

**Baby “nests”**

**Warning against baby sleep positioners**

UK shops removed infant sleep positioners (right)—also called “nests” or “anti-roll” products—from their shelves after a warning from the US Food and Drug Administration that they were a suffocation risk. In the past 13 years 12 deaths from suffocation associated with positioners have been reported in the US.

**Children’s services**

**Emergency department**

A GP in the emergency department of a paediatric hospital cuts waiting times and admissions but led to more antibiotic prescribing, a study in *BMJ Quality and Safety* found. Many hospitals have GPS co-located in emergency departments, but evidence of their benefits is scant. At Liverpool’s Alder Hey Children’s Hospital (below), children seen by a GP were less likely than children seen in the emergency department to be admitted to hospital (2.2% v 6.5%), but they were more likely to be given antibiotics (26.1% v 20.5%).

**Child mental healthcare needs “seismic” shift**

England’s children’s health commissioner called for “a wholesale shift in the scale of ambition” on children’s mental healthcare. In a report to MPs, Anne Longfield criticised the “shockingly poor” provision of services for under 18s. Her report criticised the fact that 40% of spending goes on acute care when early intervention is cheaper. Longfield called for the green paper on mental health to bring about a “seismic” change in children’s mental health services.

**Air pollution**

**MPs relaunch inquiry into government strategy**

Four parliamentary committees relaunched an inquiry into whether the government’s air quality plan goes far enough to meet legal limits and improve health. The plan was released in July after the courts twice ruled it inadequate. Sarah Wollaston, health committee chair, said, “Many people are aware of the impact of nitrogen dioxide and invisible particulates on our lungs and hearts, but new evidence suggests that they could also contribute to diseases as disparate as dementia and diabetes.” Written evidence should be submitted by 5 pm on 9 November (http://bit.ly/2g4dLj9).

**Obesity**

**In Europe, 19-49% of boys and 18-43% of girls are overweight or have obesity, representing around 12 to 16 million overweight youth**

Nathalie Farpou–Lambert, European Association for the Study of Obesity

**Childhood obesity**

**Global prevalence rises 10-fold since 1975**

The proportion of girls worldwide who are obese increased from 0.7% (five million) in 1975 to 5.6% (50 million) in 2016 and boys from 0.9% (six million) to 7.8% (74 million), an analysis in 200 countries found. But still more children are moderately or severely underweight (7.5 million girls and 117 million boys) than obese, the *Lancet*’s study found.

Cite this as: *BMJ* 2017;359:j4670

**SIXTY SECONDS ON…**

**CONCURRENT SURGERY**

**WHAT IS IT?**

A single surgeon working on two operations at the same time. It’s common in leading teaching hospitals in the US.

**HOW DOES IT WORK?**

The senior surgeon is responsible for the more critical or difficult parts of a surgery but may leave more routine parts to others.

**ISN’T THAT RISKY?**

Yes, according to the *Boston Globe*, which has been campaigning against the practice. Last week it claimed a victory when federal prosecutors opened an investigation into David Samadi (below), head of urology at Lenox Hill Hospital in New York. A high profile surgeon, he earned $6.7 million (£5.1m) in 2015.

**WHAT DOES THE HOSPITAL SAY?**

It confirms Samadi uses two theatres at the same time but performs all robotic surgeries and is present for the entirety of major surgeries. Medicare billing rules permit this, so long as patients are made aware that their surgeon may be absent some of the time.

**WHAT DO OTHER HOSPITALS THINK?**

Opinion is divided. Some, such as the University of Michigan Health System, halted the practice a decade ago. But Massachusetts General Hospital, the *Globe*’s major target, argues that concurrent surgery makes the best use of facilities and skills; benefits patients, families, and staff; and—its audits show—has a complication rate no higher than non-overlapping surgery.

**WHAT DOES THE RESEARCH SAY?**

A paper published on p59 finds that, among more than 500 000 patients having bariatric surgery in the US, adverse events at 30 days were no more common in those who had overlapping surgery than among those who had their surgeon’s full attention.

**HOW MUCH DO PATIENTS KNOW?**

US guidelines stress the need for informed consent, but some patients say they would not have undergone an operation had they known the senior surgeon would not be present the whole time. The US authors of the *BMJ* paper agree. “These results do not argue against more meaningful disclosure of concurrent surgery practices,” they said.

Nigel Hawkes, London

Cite this as: *BMJ* 2017;359:j4667
Plastic surgeons report surge in reoperations for patients originally treated abroad

Plastic surgeons are warning about a rise in the number of patients needing treatment for complications after travelling abroad for cosmetic procedures.

A review of patients at the Royal Free Hospital in London found that, from 2015 to 2017, surgeons saw 21 who had been abroad for treatment. The complications resulted in 18 episodes of inpatient admission and 46 operations. The total cost for the 21 patients was £282 000.

Patients went to a range of countries, with eastern European countries being the most common. Infection (42% of cases) was the most frequent complication, with breast procedures being the most common operation (47%).

Ash Mosahebi, professor of plastic surgery at the Royal Free, told The BMJ that in recent years his team had noticed that more patients were seeking help after being treated abroad. He said that the next step would be to look at the numbers across England. “The main issue is infection—if we don’t treat them they may end up with sepsis. Most patients come to the emergency department and we can’t turn them away. All of them need revision surgery but we don’t do that on the NHS,” he said. He said one patient lost half her abdominal skin and stayed in hospital for nearly a month.

“The problem with going abroad is that it’s difficult to get care postoperatively when you’re not in the same country as the doctor. I’m not saying all these surgeons are careless or unethical—even if they wanted to give postoperative care, they can’t,” he said.

Mosahebi said overseas surgeons come to the UK to market their services. “They come here, get a room in a hotel and give free consultations. Patients will follow them a few days later. They’re not registered as a doctor in this country but they give medical advice,” he said.

The results of the review were presented at this year’s British Association of Aesthetic Plastic Surgeons’ conference in London. To coincide with the conference, the association conducted a straw poll of its 230 members and found that many reported a rise in the number of patients coming to them with complications—about 30% of the rise was because of the growth in cosmetic surgery tourism, the poll showed.

Simon Withey, BAAPS president and a consultant plastic surgeon at the Royal London and University College Hospital, said that around 40% of his work in 2016 was revision. “Affordability is one of the biggest drivers in the rise of ‘cosmetic medical tourism’ deals offering all-inclusive package holidays and the promise of a high quality service at heavily discounted rates.

“However, these promotions conveniently gloss over the increased risk of complications, less robust regulations and the lack of follow-up,” he said.

Anne Gulland, London
Cite this as: BMJ 2017;359:j4643

Services are “straining at the seams,” warns CQC

The quality of England’s health and care services is holding up but looks increasingly precarious in a system that is “straining at the seams,” the Care Quality Commission has warned.

In its annual State of Care report the regulator said that most providers in England were continuing to provide good quality care, thanks to the dedication of staff. But it warned that the challenges associated with caring for an ageing population with increasingly complex medical needs had left the system struggling, with an estimated one in eight older people not getting the help they needed.

David Behan, CQC chief executive, said, “The fact that the quality of care has been maintained in the toughest climate that most can remember is testament to the efforts of frontline staff, managers, and leaders. However, as people’s health and care needs change and become more complex, a model of care designed for the 20th century is at full stretch and struggling to cope with 21st century problems.”

“Staff and leaders can’t work any harder; the answer must be to work more collaboratively,” he said.

The CQC reported that, as at 31 July 2017, services were rated better overall than in 2016 (see table). But the report pinpointed adult social care as an area of concern, with a decreasing number of beds in nursing homes across most of England and an increasing number of domiciliary care contracts being handed back to councils because providers said the funding was not enough to meet people’s needs. It also highlighted pressure in acute care hospitals, with more people waiting more than four hours in emergency departments and more cancellations of planned operations. It added that safety remained the biggest concern across all sectors.

Chaand Nagpaul, the BMA’s chair of council, praised the good levels of care but said that too many services were being hampered by “lack of resources, system pressures, and chronic underfunding.” Niall Dickson, chief executive of the NHS Confederation, said, “The report is unequivocal: the quality of services is in a fragile state.”

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2017;359:j4672

<p>| CQC’s ratings (% of health and care services achieving rating) in England in 2016 and 2017 |
|----------------------------------|----------------------|------------------|------------------|------------------|------------------|------------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Inadequate</th>
<th>Requires Improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice</td>
<td>3</td>
<td>2</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Adult social care</td>
<td>2</td>
<td>1</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>Mental health care</td>
<td>3</td>
<td>1</td>
<td>33</td>
<td>24</td>
</tr>
<tr>
<td>Acute hospital care services</td>
<td>5</td>
<td>3</td>
<td>39</td>
<td>37</td>
</tr>
</tbody>
</table>

14 October 2017 | the bmj
Radiologist shortage leaves patient care at risk

The UK does not have enough radiologists to meet imaging and diagnostic demands in the NHS, the Royal College of Radiologists has warned. Nearly all radiology departments in the UK (97%) said that they had been unable to meet their diagnostic reporting requirements in 2016 within their radiology staff’s contracted hours, the college’s 2016 census report found. “This points to an insufficient number of radiologists to meet the increasing demand for imaging and diagnostic services,” it said.

The census received responses from all 202 radiology department leads in the UK. The workforce crisis comes at a time of well documented shortages in other specialties, including paediatrics, obstetrics, emergency medicine, rheumatology, psychiatry, and general practice.

Radiology has the second lowest proportion of trainees to consultants when compared with other hospital based specialties, said the report, with 26 trainees for every 74 consultants, compared with an average in all specialties of 40 trainees for every 60 consultants. “This raises questions about the future replenishment and sustainability of numbers in the consultant workforce,” the report warned.

The census also found that nearly one in 10 UK radiologist posts (8.5%) were vacant during 2016, nearly two thirds of which (61%) were unfilled for a year or more. Although the proportion of whole time equivalent consultant radiologists in the UK increased by an average rate of 3% a year over the past six years, the workforce has not kept pace with an increase in clinical demand, the report noted.

The workforce shortage was particularly prominent in Scotland, where the consultant workforce grew by 7% from 2010 to 2016 but demand for computed tomography and magnetic resonance imaging scans increased by over 10%.

The census also found that 22% of the consultant radiologist workforce (698 consultants) were predicted to retire in the next five years. The report said that this and the shortage of consultants raised questions about “the sustainability of radiology services in the near future,” adding, “Unless the situation is addressed urgently, there is a clear risk that patient care will be significantly affected.”

The NHS paid nearly £88m in 2016 for backlogs of radiology examinations to be reported, the census found—an amount that could have paid for at least 1028 full time radiology consultants.

To cover the backlog, 92% of radiology departments paid radiologists to work overtime, 78% outsourced reporting to independent teleradiology companies, and 52% employed ad hoc locums.

Abi Rimmer, The BMJ
Cite this as: BMJ 2017;359:j4683

FIVE MINUTES WITH . . .

Nicola Strickland

The president of the Royal College of Radiologists talks about why the specialty can’t be allowed to fail

“I am not exaggerating. Radiology is the linchpin to every medical diagnosis in the hospital. Every major surgical operation requires imaging and every cancer pathway depends on imaging. There isn’t a single part of modern medicine or surgery that doesn’t need radiology, so if nothing is done it could result in the collapse of NHS services.

“At the moment we have thousands of patients’ scans and x rays waiting more than a month for a report. Things will be missed for a period of time (until the scan is reported), which may be harmful. There’s also the stress and anxiety suffered by the patient during this delay.

“The only sustainable and cost effective solution is to train more radiologists. We need about 360 extra every year for the next five years to equal even the mean number of radiologists per 100,000 population in the rest of Europe. Of course, if the government could give us the money for the training, then we would be out of this mess and the specialty would be sustainable.

“Although some scans are outsourced we need radiologists in hospitals because reporting imaging studies is only a tiny proportion of what we do. The whole of interventional radiology is performed by radiologists—for example microsurgery, like stopping emergency bleeding after childbirth, or taking biopsies for cancer, is done by radiologists.

“In the hospital, we are constantly interrupted by clinicians wanting us to go over scans or imaging and give a second opinion, and discuss it. We advise on what the best imaging pathway is going to be for a particular patient. There is absolutely no way you can run a radiology service without radiologists sitting in the hospital.

“People don’t appreciate that, even in my lifetime in radiology, the actual nature of our specialty has changed hugely. We now do so many different types of procedures and examinations, with the nature of the examinations becoming ever more complex.”

Abi Rimmer, The BMJ
Cite this as: BMJ 2017;359:j4675
Firearm injuries cost the United States $2.8bn (£2.1bn) a year in hospital charges and $46bn a year in lost work and medical care, a new study has shown.

The report in Health Affairs analysed a nationally representative sample of patients who presented alive to US hospital emergency departments with firearm related injuries from 2006 to 2014.

The authors, using data from the Nationwide Emergency Department Sample, identified 151 000 patients—representing a weighted total of 705 000 nationally—who presented with gunshot wounds. The study found that males were nine times more likely than females to be gun victims, with men aged 20 to 24 at the highest risk.

More than a third (37.2%) of the injured patients were admitted to inpatient care, while 8.3% died in the emergency department or during inpatient admission, the study found.

The mean charges per person were $5254 for emergency department patients and $95 887 for inpatients, resulting in an annual financial burden of around $2.8bn, the study estimated.

The authors said, “Despite the high clinical and financial burden associated with firearm-related injuries, resources allocated to preventing them remain low. Future policies related to firearms should focus on better understanding and preventing these injuries. “Although future research is warranted to better understand

### WHO advises blanket anti-worming care for children despite

The World Health Organization has strongly recommended the mass treatment of hundreds of millions of children to eliminate worm infections, while admitting that evidence does not prove that it will do any good.

A Cochrane review published in 2015 by a team at the Liverpool School of Tropical Medicine found no evidence that eliminating intestinal worms by treating all children in an area where worms were endemic improved the children’s average height, weight, or nutritional status. A Campbell review published in 2016 confirmed these findings.

The WHO guideline does not dispute that conclusion.

Paul Garner, of the LSTM, who is coordinating editor of the Cochrane Infectious Diseases Group, said, “WHO recommends community deworming despite the evidence providing reasonably good evidence of no effect. It is sleight of hand to make a strong recommendation based on low quality evidence.”

Dirk Engels, director of WHO’s neglected tropical diseases department, claimed that a “global evidence based consensus” now shows that periodic, large scale deworming is the best way to reduce suffering caused by intestinal worms.

The panel’s rationale for its recommendation comes from trials showing that children known to be infected did show benefits from deworming. The logical conclusion would be to test children and to identify and treat those infected, but this is more expensive than simply treating all children regardless of whether they are infected.

Garner said, “Obviously, children with worms should be treated. But the argument is whether you embark on deworming every child in a continent to ensure this. And it isn’t cheap—the overall costs are high, when you add it all up.”

He also questioned whether the WHO panel should emphasise weight gain seen in children known to be infected. The Cochrane group, in its assessment, did not pool the results for weight gain, because two studies carried out 30 years ago in Kenya showed large effects not seen in more recent trials.
firearm-related injuries, policymakers might consider implementing universal background checks for firearm purchases and limiting access to firearms for people with a history of violence or previous convictions to reduce the clinical and financial burden associated with these injuries.”

Meanwhile, a research letter published by JAMA Internal Medicine compared the proportion of terrorist attacks committed with firearms in the US with the proportion in other high income countries, and it compared the deadliness of attacks with firearms with those by other means.

In countries with 10 or more terrorist attacks, the proportion involving firearms was higher in the US (20.4%) than in any other country. Second was the Netherlands (14.3%). Overall, firearms were used in less than 10% of terrorist attacks from 2002 to 2016 but accounted for about 55% of the deaths.

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2017;359:j4641

lack of evidence

Deworming has long been seen by campaigners as a panacea for health, education, and development problems in poor countries. In 2005, WHO claimed that eliminating worm infections would improve intellectual development and cognitive function and help meet the millennium development goals; but the new guideline does not mention these claims, which were based on a single randomised trial whose methods have been contested. A recent reappraisal of the data from that trial did not support its main conclusions.

But many influential bodies, including the Gates Foundation (which provided funds for the preparation of the WHO guideline), remain committed to deworming.

Nigel Hawkes, London
Cite this as: BMJ 2017;359:j4589

CONSERVATIVE PARTY CONFERENCE REPORT

NHS plays second fiddle to Brexit as prime minister struggles to find voice

After the buzz of the past two party conferences, in which the Tory faithful were giddy from an unexpected majority (2015) and an unexpected Leave vote (2016), it was perhaps inevitable that the 2017 vintage lacked the same fizz. Their confidence has been punctured by the unexpected loss of a parliamentary majority and the unpredicted gains made by the Labour Party in June.

The Conservatives are divided over Brexit, and the authority of the prime minister, Theresa May, has been badly weakened by the election. As potential successors plot behind the scenes, this conference was supposed to be a platform for May to reassure her authority. But her speech was plagued by bad luck and descended into farce, as a prankster handed her a spool of P45 (notice of termination of employment), the stage set fell apart behind her, and a cough left her struggling to deliver her speech.

With Brexit looming large, health did not feature prominently during the Manchester conference (aside from May’s unfortunate throat problem). The prime minister detailed a couple of key health policy announcements: a proposal to move to an opt-out system of organ donation in England, and a new inquiry into the effectiveness of the Mental Health Act. But, unfairly or not, her speech won’t be remembered for these items and will go down in history for all the wrong reasons.

The health secretary for England, Jeremy Hunt, was among those to rally round May, praising her resilience while joking that hers may go down as “one of the most famous coughs in British history.” Thankfully, despite his five years in the job, he didn’t attempt an on-the-spot diagnosis.

Hunt’s key offers

The previous day Hunt had delivered his own keynote speech, with a series of announcements on workforce (including a 25% increase in the number of nurse training posts), an offer to give NHS staff first refusal to buy affordable housing built on surplus NHS land, and new flexible working arrangements.

Hunt clearly recognises how crucial the workforce issue will be in the wake of Brexit. But though he sounded sincere when telling NHS staff from other EU countries, “You do a fantastic job. We want you to stay, and we’re confident you will be able to stay with the same rights you have now,” he failed to provide any detail of how this was going to happen, a consistent flaw in the government’s Brexit pledges.

He drew heavily on statistics as he outlined his drive to stop him taking aim at the “public spending commitments” narrative makes one wonder if his endurance as health secretary has taken him too far down the rabbit hole. But perhaps this was a deliberate attempt to display his “strong and stable” grasp of his brief.

Though Hunt’s speech was sparsely attended, it was well received by the delegates who were there, particularly when he introduced a Pathé news clip of the former Tory health minister Henry Willink announcing the initial white paper for a national health service in 1944. This, Hunt claimed, showed that it was the Tories, not Labour, who invented the NHS and that Labour did not have “a monopoly on compassion” (a line that May later recycled in her speech).

Hunt pointedly criticised Labour for supposedly using the NHS to score points politically at its own annual conference the previous week. But this didn’t stop him taking aim at the public spending commitments of Labour’s leader, Jeremy Corbyn, and shadow chancellor, John McDonnell, which he warned would leave the NHS “on its knees.”

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2017;359:j4636

Theresa May’s cough was one of few health talking points from the conference

CONSERVATIVE PARTY CONFERENCE REPORT

NHS plays second fiddle to Brexit as prime minister struggles to find voice

After the buzz of the past two party conferences, in which the Tory faithful were giddy from an unexpected majority (2015) and an unexpected Leave vote (2016), it was perhaps inevitable that the 2017 vintage lacked the same fizz. Their confidence has been punctured by the unexpected loss of a parliamentary majority and the unpredicted gains made by the Labour Party in June.

The Conservatives are divided over Brexit, and the authority of the prime minister, Theresa May, has been badly weakened by the election. As potential successors plot behind the scenes, this conference was supposed to be a platform for May to reassure her authority. But her speech was plagued by bad luck and descended into farce, as a prankster handed her a spool of P45 (notice of termination of employment), the stage set fell apart behind her, and a cough left her struggling to deliver her speech.

With Brexit looming large, health did not feature prominently during the Manchester conference (aside from May’s unfortunate throat problem). The prime minister detailed a couple of key health policy announcements: a proposal to move to an opt-out system of organ donation in England, and a new inquiry into the effectiveness of the Mental Health Act. But, unfairly or not, her speech won’t be remembered for these items and will go down in history for all the wrong reasons.

The health secretary for England, Jeremy Hunt, was among those to rally round May, praising her resilience while joking that hers may go down as “one of the most famous coughs in British history.” Thankfully, despite his five years in the job, he didn’t attempt an on-the-spot diagnosis.

Hunt’s key offers

The previous day Hunt had delivered his own keynote speech, with a series of announcements on workforce (including a 25% increase in the number of nurse training posts), an offer to give NHS staff first refusal to buy affordable housing built on surplus NHS land, and new flexible working arrangements.

Hunt clearly recognises how crucial the workforce issue will be in the wake of Brexit. But though he sounded sincere when telling NHS staff from other EU countries, “You do a fantastic job. We want you to stay, and we’re confident you will be able to stay with the same rights you have now,” he failed to provide any detail of how this was going to happen, a consistent flaw in the government’s Brexit pledges.

He drew heavily on statistics as he outlined his drive to stop him taking aim at the “public spending commitments” narrative makes one wonder if his endurance as health secretary has taken him too far down the rabbit hole. But perhaps this was a deliberate attempt to display his “strong and stable” grasp of his brief.

Though Hunt’s speech was sparsely attended, it was well received by the delegates who were there, particularly when he introduced a Pathé news clip of the former Tory health minister Henry Willink announcing the initial white paper for a national health service in 1944. This, Hunt claimed, showed that it was the Tories, not Labour, who invented the NHS and that Labour did not have “a monopoly on compassion” (a line that May later recycled in her speech).

Hunt pointedly criticised Labour for supposedly using the NHS to score points politically at its own annual conference the previous week. But this didn’t stop him taking aim at the public spending commitments of Labour’s leader, Jeremy Corbyn, and shadow chancellor, John McDonnell, which he warned would leave the NHS “on its knees.”

Gareth Iacobucci, The BMJ
Cite this as: BMJ 2017;359:j4636

Theresa May’s cough was one of few health talking points from the conference
THE BIG PICTURE

Plague season hits Madagascar

A worker from Madagascar’s Ministry of Health disinfects a school in the capital Antananarivo, one of 10 cities to have been hit by pneumonic plague.

Although plague is endemic to Madagascar, this the first time the most virulent form of the disease has been seen in the country’s densely populated urban areas, said the World Health Organization. Bubonic plague predominates, generally affecting remote areas, but the government confirmed last month that a Seychelles national had died from pneumonic plague on 27 September.

Plague is caused by the bacteria *Yersinia pestis*, found in small mammals and their fleas. Humans can be contaminated by the bite of infected fleas (bubonic), direct contact with infected materials (septicaemic), or inhalation (pneumonic). In total, 73 cases of pneumonic plague, including 17 deaths, were reported from 23 August to 30 September. Antananarivo has seen most cases (27, 7 deaths), followed by the eastern port of Toamasina (18 cases, 5 deaths) and central Faratshio (13 cases, 1 death).

Fifty eight cases of bubonic plague have also been recorded, including seven deaths—more than expected for the time of year, said WHO. Bubonic plague affects around 400 people a year on the island.

"WHO is concerned that plague could spread further because it is already present in several cities and this is the start of the epidemic season, which usually runs to April," said Charlotte Ndiaye, a spokeswoman for WHO, which has released $300 000 (€226 000) to fund the supply of antibiotics and personal protective equipment. It has appealed for $1.5m to support its response.

No travel restrictions have been issued but WHO said that travellers visiting rural areas should be aware of the outbreak.

Zosia Kmietowicz, The BMJ

Cite this as: BMJ 2017;359:j4595
Data, data everywhere…

Can public trust in sharing health records be regained? Will clinicians end up frazzled data inputters? Stephen Armstrong looks at healthcare’s wrestling match with figures produced by 65 million people

“O

ne of the most important resources held by the UK health system is the data generated by the 65 million people within it,” wrote John Bell, regius professor of medicine at Oxford University, in the government’s Life Sciences Industrial Strategy published in August.

“The development of platforms to enable de-identified health data to be appropriately used to research and develop technologies would be of great benefit to patients, to those managing the NHS, and to researchers attempting to develop new therapies or improve NHS care,” continued Bell, who is also chairman of the Office for the Strategic Coordination of Health Research, which coordinates the research of the National Institute for Health Research and the Medical Research Council.

NHS records, he argued, are uniquely suited to helping develop powerful algorithms that could transform healthcare and seed an “entirely new industry” in diagnostics based on artificial intelligence (AI). Bell’s strategic goal for the NHS is to develop 50 separate programmes in collaboration with industry over the next five years, including large scale data analysis.
And yet—at a panel discussion organised by Stanford Medicine and the Royal College of Physicians that asked, “Are data and analytics the new medicine?” and just five days after Bell’s strategy was published—experts from both sides of the Atlantic warned that serious problems lie ahead.

**Patient trust and technology**

“Personalised medicine isn’t overhyped,” said Jem Rashbass, national director for disease registration and cancer analysis at Public Health England. “It is spectacular when it works. It’s important to find and identify the right people—and to do that you need molecular data and clinical data sets. But we have issues with patient trust, security, and technology to overcome first.”

In theory, all UK patient and care records will be digital, real time, and interoperable by 2020, according to a 2015 speech by Jeremy Hunt, the health secretary. All patients will be able to access their general practice records online in full, he has said, including drugs, allergies, test results, appointment records, histories, and all interactions with health and care services.

In April, however, a report by health technology analysts Digital Health Intelligence concluded that NHS hospitals won’t be paperless until at least 2027. And data collection causes stress for many clinicians, who say that their time with patients is suffering.

**Data driven burnout**

“More than 50% of physicians practising in the US are experiencing at least one symptom of burnout,” said Lloyd B Minor, dean of Stanford University’s School of Medicine. “It’s a national problem with a variety of causes—but the electronic medical record is the one most commonly cited.”

At a medical technology conference in San Francisco in July, more than two thirds of doctors said that increased reliance on technology, such as electronic health records, served only to separate them from their patients.

UK doctors agree. “Fifteen years ago, when I was writing discharge summaries for my patients, I could write the summary in 10 minutes and send it on to their GP,” said Giles Armstrong, a consultant in emergency paediatric medicine at Whittington Hospital, in north London.

“Now my juniors are taking 45 minutes to input all the data from admission. We’re using all this medical manpower to input data.”

**Check-in at the airport**

For Margaret Johnson, a consultant in respiratory medicine at the Royal Free Hospital in Hampstead, London and academic vice president at the Royal College of Physicians, technology is both the problem and the solution.

“Sometimes I have four fields open on my screen when I’m talking to patients: I feel like the check-in desk at the airport,” she said. “If there was an AI in the room—like Amazon’s Alexa [a voice activated digital personal assistant]—it might be able to record and transcribe the conversation without the doctor having to endlessly type, or retrieve and open x rays with speech commands.”

Some US hospitals have considered using Alexa for transcribing medical notes, but the software does not meet legal standards for manipulating patient health data.

Clinicians may not find AI is entirely on their side, however. “If you have junior doctors working with AIs analysing x rays to the same standard as a consultant, you will get care that’s better: faster and cheaper,” said Sam Smith, spokesperson at Med Confidential, which advocates for privacy of medical data.

“To train an AI, you don’t need everything, you just need enough. But what researcher ever said they didn’t want more data?”

**DeepMind undermined public trust**

In the UK, several high profile data breaches have helped undermine public trust. Rashbass cited the 26 million GP records made accessible to strangers; the Information Commissioner’s Office (ICO) fining an HIV clinic £180 000 after it released data on 781 of its patients; and
Privacy impact assessments

Denham urged NHS trusts to assess the impact on privacy when planning a new innovation or trial and to ensure any processing of personal data is legal. “Just because evolving technologies can allow you to do more it doesn’t mean these tools should always be fully utilised,” she said.

She added: “In this case, we haven’t been persuaded that it was necessary and proportionate to disclose 1.6 million patient records to test the application. You should consider whether the benefits are likely to be outweighed by the data protection implications.”

In June, DeepMind signed a five year deal with Taunton and Somerset NHS Foundation Trust. As well as being used to identify possible acute kidney injuries, the trust’s Musgrove Park Hospital plans to use Streams as an electronic patient record of all relevant information, including radiology and blood tests.

As part of its privacy impact assessment in April, the trust decided that “as patient data will be used for the purposes of direct care, patient consent will not be explicitly sought.” It also said that it would not be feasible. For Rashbass, this doesn’t go far enough. “Patients have anxieties about the misuse of their data, especially when a commercial company is involved. We have damaged patient trust. It is a very difficult process to reverse.”

US patients are keener to share

According to Euan Ashley, professor of medicine at Stanford University: “There’s a difference between patients in California asking what value their data can bring compared with UK fears about privacy and data. Over 45% of Americans have had some sort of breach of health records, but when people understand the benefits to them and their families they are happier to share.”

In the US and the UK, data sharing is hampered by systems’ incompatibilities. Attempts to overcome this have faltered; the NHS’s attempt at a single centralised system to connect all care providers (the NHS National Programme for IT) cost £12bn before it was cancelled in 2011.

“The data are Balkanised, even in different systems within one provider,” said Rashbass.

“We currently have remarkably fragmented sources of data with multiple gatekeepers, because of the politics and culture of the health service,” agreed Charlie Davie, managing director at NHS innovation group UCL Partners. Davie cited initiatives for data collection, such as the Medical Research Council funded institute for bioinformatics Health Data Research UK, which was set up to collate multiple sources of data.

“We are frequently unable to get a data set that is comparable, as the data is haphazard and fragmented,” said Rashbass.

“In some cases, you can usually get a patient’s history, but they may not have come through the hospital system before. The same applies to ambulance data. Patients are often in hospital but the ambulance data might not have been stored because the ambulance crew were the first to arrive. Or they might have been seen by a general practitioner (GP) before being admitted to hospital.”

Stephen Armstrong is a journalist, London

stephen.armstrong@me.com

Cite this as: BMJ 2017;359:j4546
The NHS is “broken” according to Andrew Mawson, social entrepreneur and cross-bench peer. But unlike the “liberal Guardian readers,” whom he says produce policy documents but don’t get things done, he is doing something to tackle the problem.

Mawson is the driving force behind the transformation of a community in Tower Hamlets, east London, the ultimate aim of which is to improve residents’ health, wellbeing, and prospects. He wants to cut through the bureaucracy and “liberal rhetoric” he believes stifles the possibility of real change in deprived areas.

The St Paul’s Way project, launched in 2006, has brought together a secondary school, housing association, pharmacy, and—finally, in January—a general practice to help transform the road and the community around it. The idea is that all of these collaborating organisations—staffed by local people and involving the community—will be better able to deliver the desired changes.

Mawson compares this ethos to a department store—you may go in to buy a kettle, but while you’re there you might also pick up a birthday card, and have a coffee. “We’re not gatekeepers here, we’re gate openers. We want people to stay in our centres. We think health is all our business—not just the business of doctors,” he says.

There’s two way traffic: Hall also chairs the school’s governing body, and pupils are conducting research on diabetes in the practice premises’ laboratory. Hall is hoping residents
will soon be able to make use of the school’s sports facilities at weekends.

**Community involvement**

For Hall, recruiting local people has been key to this integration; he has replaced the whole clinical and managerial team. “When I took over it was being run by a private firm based in Paris,” he explains.

Practice manager Anwar Hussein went to the local school, and all the reception staff and GPs live locally, “I recruited GPs who all committed themselves to transforming the area,” Hall says. “The practice is in one of the most deprived wards in the country—there are high rates of early mortality, chronic disease, and cancer.”

Mawson believes that the people who can transform services are the people using the services. “You have to give real money and real power to people,” he says. Every month the health centre holds a meeting with various local groups such as churches, mosques, and the school, to ensure they are getting the services they need.

The centre also trains 20 people at a time to become health champions, work funded by financial services company Morgan Stanley. “They teach other people registered with the practice about the health service and how to manage their health better. “They often know better than us what doesn’t work. We have to trust local people to make better decisions,” says Hall.

The practice has a high consultation rate, so it is looking at ways of introducing online or telephone consultations and “educating” patients about how to get the most out of appointments. Hussein runs a monthly clinic to discuss the running of the practice—patients told him they would like to be informed when appointments are running late so now there’s a sign showing any delays.

Patients can also use the centre’s noticeboards. For example, there was a display created by local women on domestic violence: its effects on women and children, how to spot the signs, and how to seek help.

**This is not McDonald’s**

At the end of the school day, a gaggle of pupils head into a fast food outlet. Does a purveyor of fatty, salty food opposite a school fit with the St Paul’s Way ethos? Mawson purses his lips and mutters, “That’s planning for you.”

This sums up his beef with the “Well North” banner. Mawson adds, “The fact we’re not building the same thing everywhere.”

The model also has an influential supporter in former NHS chief executive Nigel Crisp, now chair of the all-party parliamentary group on global health, who has espoused its virtues in outlets as diverse as The BMJ and the Big Issue.

Crisp is supportive of St Paul’s Way because he believes it embodies the idea that health is not just the preserve of the NHS but of all society. “What I’m interested in is that the project is not about healthcare but about health and about health in association with everything else,” he says.

“The NHS is great, but it cannot do everything and shouldn’t behave as if it can. It can’t do anything about people being lonely or the causes of mental [ill] health. St Paul’s Way is about creating a health creating environment.”

Anne Gulland, Freelance journalist, London
agulland@bmj.com

Cite this as: BMJ 2017;359:j4594

65% of residents are of black or other minority ethnic origin, compared with the Tower Hamlets average of 54%

27% of homes in the Mile End ward are owner occupied, compared with London’s average of 50%

English, has access to welfare and benefit services, and can learn skills. That’s positive, but it will only happen 10 years or so down the line,” he says.

Mawson adds, “The fact we’re rebuilding housing will have major implications for local people. It’s not about what happens in that health centre—it’s about the whole estate.”

When asked whether the St Paul’s Way model could be replicated elsewhere Mawson gives an unexpected answer: “No! This is not McDonald’s. Let’s not build the same thing everywhere.”

**Support in high places**

However, the model—or the idea, at least—is being introduced into 10 areas in the north of England under the “Well North” banner. Mawson is working with communities that have traditionally had poor health outcomes, trying to get local people to effect change themselves.

“There’s a whole health village we could build opposite the teaching hospital in Bradford,” he says. “It would be unique to Bradford and led by the people of Bradford. All the issues I have seen on St Paul’s Way, I have seen in Manchester and Bradford. How many doctors have talked to the priest or the pharmacist, or anyone else in the community?”

The model also has an influential supporter in former NHS chief executive Nigel Crisp, now chair of the all-party parliamentary group on global health, who has espoused its virtues in outlets as diverse as The BMJ and the Big Issue.

Crisp is supportive of St Paul’s Way because he believes it embodies the idea that health is not just the preserve of the NHS but of all society. “What I’m interested in is that the project is not about healthcare but about health and about health in association with everything else,” he says.

“The NHS is great, but it cannot do everything and shouldn’t behave as if it can. It can’t do anything about people being lonely or the causes of mental [ill] health. St Paul’s Way is about creating a health creating environment.”
**EDITORIAL**

**Tobacco giant wants to eliminate smoking…**

…and pigs might fly

The Foundation for a Smoke-Free World, an “independent” research funding body fully funded by tobacco company Philip Morris, launched on 13 September. It will provide $960m (£711m) over 12 years to help “eliminate smoking worldwide.” No benchmarks for this modest task have apparently yet been announced. This largesse is a mere $80m a year from a company with global revenue in 2016 of $26.7bn and a marketing budget (in 2012) of $7bn intended overwhelmingly to promote smoking.

The long, deceptive, and failed history of tobacco harm reduction has seen filters (including crocidolite asbestos); misleading “reduced carcinogen” brands; and a wide range of breathtakingly announced innovations. Each had their academic touts. None reduced harms from smoking. Electronic vapers may turn out to be the real deal. But with less than a decade of widespread use, any verdict on their status as a decade premature.

**Vapourised products**

The vapourised nicotine industry, including Big Tobacco, is now focused on how it can break down potent regulatory controls on vapourised products and assure consumers about safety.

In the past, Philip Morris has publicised seductive research and courted prominent scientists, including US epidemiologist Ernst Wynder, the first proponent of tobacco harm reduction. The new foundation’s director, Derek Yach, former leader of the World Health Organization’s tobacco control programme, is acutely aware of why it does this, having written powerfully in 2001 about the industry “buying scientists” to serve commercial objectives and help thwart tobacco control.

Will this be a modern Faustian tale, as many expect, or will Yach have the success with Philip Morris that he failed to experience in trying to turn Pepsi into a health oriented company for six of his post-WHO years? Doubtless he will have a predictable coterie of supplicants for the foundation’s money. But the breathtaking arrogance of Philip Morris and Yach shunning WHO’s article 5.3 on industry interference in the Framework Convention on Tobacco Control will surely steel the resolve of thousands of researchers to continue to shun money obtained from tobacco sales.

Nearly 120 health organisations have called on the company instead to simply stop selling cigarettes.

This is, of course, thoroughly naive. Shareholders will prevent any serious attack on the company’s profitability to which cigarettes are central. Euromonitor estimates that the 2016 global market for combustible tobacco was $7.36bn while that for e-cigarettes was $1.12bn.

If Philip Morris really wanted smoking rates to decline it could announce tomorrow that it is voluntarily introducing large graphic health warnings and plain packaging on all its tobacco products. It could massively increase its wholesale prices. It could stop all advertising and sales promotions. But Philip Morris and other tobacco companies will do none of this and instead continue to reward staff who increase tobacco sales.

“Useful idiots”?

So will Yach actively join the world tobacco control community in attacking such activities or will he be historically numbered among prominent “useful idiots,” as Lenin might have called them, formerly working in tobacco control, who now attend global tobacco industry meetings to cheer on their tobacco host’s “game changing” while doing nothing about this industrial vector’s daily efforts to promote smoking?

Disturbingly, the main task for tobacco control is now increasingly framed by such tame experts as convincing smokers to switch to vapourised products, not preventing and quitting smoking. Some even talk of vaping by children as being “protective” against future smoking.

Over many decades, governments have acted to ban a huge range of unsafe, deadly products (thalidomide, asbestos, chlorofluorocarbons, countless unsafe consumer goods), and exploitative practices (people trafficking, child labour). With tobacco companies now embracing the rhetoric of the end of smoking, it is time for governments to take the industry at its word and set those dates when combustible tobacco products will be banned.

Simon Chapman, emeritus professor, School of Public Health, University of Sydney simon.chapman@sydney.edu.au

Cite this as: BMJ 2017;358:j4443

Find the full version with references at http://dx.doi.org/10.1136/bmj.j4443
Inadequate mental health services for children

The ongoing crisis is evidence of systematic discrimination

In recent years children’s mental health has received less than 1% of the overall health budget, although, as children grow into adults, mental health problems account for 23% of disease burden in the UK. Many affected children remain invisible and increasing pressures in child and adolescent mental health services have been highlighted in numerous reviews. In an extraordinary judgment, James Munby, president of the High Court’s family division, recently condemned the “disgraceful and utterly shaming lack of proper provision in this country” for young people.2

Children face long waits to access support with a wide variation in quality of services, and children who need inpatient care can be sent far from home, isolated from friends and families when they are at their most vulnerable. Not one young offender institution inspected in England and Wales has been found to be safe enough for young people, and at the same time self harm rates in our prisons have doubled since 2010.6

Unmet need
This all adds up to an overwhelming sense that children are being discriminated against by broader society.

Mental health research receives disproportionately low funding compared with physical health, and less than 30% of this funding is spent on children and young people. The last comprehensive prevalence study in the UK was done over a decade ago. This will finally be updated next year, but there are clear indications that need has soared in some areas. For example, UK hospital admissions for self harm in children and adolescents increased by 50% between 2005 and 2015.12 We need the government to commit to regular timely surveys to plan for effective services as well as to achieving parity in research funding.

We also need to hold commissioners to account for consistent investment across child and adolescent mental health services. The Royal College of Psychiatrists uncovered a postcode lottery in spending last year, with wide variations in availability and quality of services; 20 clinical commissioning groups spend just £30 per child.11

The government has pledged to treat at least 35% of children and young people with a diagnosable mental health condition by 2020.12 Achieving this will be a challenge. And what about the other 65%? It is unthinkable that this very low target would be acceptable for children and young people with physical conditions. Nevertheless, it is promising that the Departments for Health and Education are working together on the forthcoming green paper on children and young people’s mental health, and the opportunities offered by this legislation must be maximised.

The recent government workforce report on mental health13 is also welcome, although delivery will be challenging. Since 2014, when the government published Future in Mind, the number of child and adolescent psychiatrists has fallen by 7%.14 Even with the new workforce report’s calls for an additional 100 psychiatrists, it will be difficult to meet needs.

Language barrier
It takes a whole village to raise a child. We need communities and systems to work together to ensure the right support is easily accessible. Communication is often a barrier to collaborative working between health and other agencies; we need to speak the same language, understand what really matters to children and young people, and deliver the right training. Young people often report that when they finally summon up the courage to seek help, they see a professional who seems as scared as they are and does not have the confidence and training to help them, making them feel even more vulnerable.

Finally, we need to give young people a voice at every level and empower them to shape their future. In the words of Nelson Mandela, “There can be no keener revelation of a society’s soul than the way in which it treats its children.”

A dark shadow has been cast on our soul but we can act now to move swiftly into the light.

Bernadka Dubicka, chair
bernadka.dubicka@manchester.ac.uk

Tori Bullock, service user representative, Child and Adolescent Faculty, Royal College of Psychiatrists, London

Cite this as: BMJ 2017;358:j4254

Find the full version with references at http://dx.doi.org/10.1136/bmj.j4254