Bank mis-selling costs GPs millions

**EXCLUSIVE:** General practices have had to pay out millions of pounds after they bought interest rate hedging products mis-sold to them by banks, *The BMJ* has learnt.

In some cases the deals have left GPs struggling to retire or to sell their practices.

Interest rate hedging products, or “swaps,” are designed to help buyers manage fluctuations in interest rates with fixed rate deals. They were sold to small businesses seeking loans from 2001.

But in 2013 the Financial Conduct Authority found that there had been “serious failings” in the sale of these products and that 90% had been mis-sold.

*The BMJ* has learnt of at least 10 medical centres hit by the scandal. Experts predict that many more may have been affected.

One practice, the Ridge Medical Practice in Bradford, paid out an estimated £3.6m to the Royal Bank of Scotland in interest between 2007 and 2015 after it took out a 26 year swap along with a £9.5m loan to fund new premises. The bank has refused to pay any compensation to the practice.

Nick Nurden, the Ridge practice’s business manager, told *The BMJ*, “They presented it to us as the only option, but there were far better products that would have been easily affordable and done the same job of providing that security. We were sold a pup on day one.”

Another affected practice in central England took out a loan and swap with RBS in 2006. After renegotiating the deal in 2011, the debt rose from £9.5m to £14.7m. Again, it has received no compensation. A GP at the practice who wished to remain anonymous said, “We were misled. The perceived benefits were emphasised and any downside was hardly mentioned at all.”

Nick Stoop, founder of Warwick Risk Management, which advises businesses affected by mis-selling, has worked with 10 medical centres adversely affected. He said, “It’s difficult to attract new partners into the practice because of a massive liability. It’s difficult to retire because they have got to carry on servicing [the loan], and it’s difficult to sell for the same reason.”

An RBS spokesperson said, “Ridge Medical was part of the FCA-agreed review, but, taking into consideration all the available evidence, we concluded that it would have again entered into a long-dated swap had the sale fully met the standards agreed with the FCA.”

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“GP competency doesn’t cover transgender care”

GPs are putting themselves and patients at risk by acting beyond their competency to provide care for transgender patients, the BMA has said.

In response to an NHS England consultation on changes to gender identity services for adults, the BMA said, “We are concerned both about the safety of patients who are prescribed drugs off licence by a non-specialist prescriber, where there is a potential for harm to the patient and consequent medicolegal risk to GPs.”

Robert Morley (left), executive secretary of Birmingham Local Medical Committee, said that most GPs had little experience of the hormonal drugs that they were being asked to prescribe. “Patients are being put in a position where they are not able to obtain their drugs unless their GP acts outside of their experience and competence.”

He added that GPs who felt unable to prescribe specialist hormonal drugs were at risk of complaints. “There is a culture of encouraging complaints against GPs for refusing to prescribe,” he said.

In its consultation response, the BMA called for NHS England to implement a directed enhanced service (DES) to allow GPs and practices with the appropriate specialist skills to provide gender identity services.

Abi Rimmer, The BMJ  Cite this as: BMJ 2017;359:j5106

General practice
Care “is worse” at limited company clinics

Patients registered at general practices in England that are owned by limited companies, including large organisations, reported worse experiences of care than other patients, a study showed. Researchers from Imperial College London examined GP patient survey responses from 7949 practices in England. Reporting in the Journal of the Royal Society of Medicine, they examined the frequency of consulting a preferred doctor, the ability to get a convenient appointment, ratings of doctors’ communication skills, ease of contacting the practice by phone, and the patient’s overall experience.

E-consultations are popular with patients . . .

Six in 10 people (63%) would rather consult their GP online than wait an average of 13 days for a face-to-face appointment, a poll suggested. The YouGov survey of 2000 UK adults, commissioned by the online system eConsult, found that 69% of 18-24 year olds would rather consult online than wait 13 days, compared with 60% of over 55s. Murray Ellender, a GP in south London and cofounder of eConsult, said that the results provided “tangible evidence” that patients are willing to embrace e-consultations.

. . . but offer few benefits for practices

E-consultations seem to offer some benefit to patients but increase GPs’ workload, research in the British Journal of General Practice found. A 15 month pilot study of the eConsult tool looked at 36 practices in the West of England region in 2015-16. Most resulted in GPs needing to follow up with phone or face-to-face appointments because they had insufficient information for clinical decision making.

NHS to test GP appointments by smartphone

NHS patients will be offered “virtual” GP consultations 24 hours a day using a video link on their smartphones in a new scheme being piloted in London. The service, launched by a group of GPs and the healthcare company Babylon, promises patients access to video consultations within two hours. But Helen Stokes-Lampard (below), chair of the Royal College of GPs, expressed concern that this may create a two tier system by cherry picking younger, healthier patients and leaving traditional GP clinics to treat older patients and those with more complex health needs.

Clinical guidelines
DNA test for familial hypercholesterolaemia

GP medical records should be systematically examined to identify people at risk of familial hypercholesterolaemia, says updated NICE guidance. Some 260 000 people in the UK are thought to have the condition, but only around 15% of cases are diagnosed. NICE recommends records of patients with total cholesterol concentration above 7.5 mmol/L (age <30) or 9.0 mmol/L (age ≥30) should be scrutinised.

Low glaucoma risk should not be referred

People with risk factors for glaucoma should be referred to specialist care only when their inner eye pressure reaches 24 mm Hg, a new NICE guideline says. Current practice is to refer patients with inner eye pressure of over 21 mm Hg.

Public health
PHE urges parents to make sure children get flu jabs

Parents should ensure their children are vaccinated before the winter flu season begins, Public Health England advised. Schoolchildren up to year 4 (aged 7 and 8) can receive a free vaccination at school by nasal spray. PHE is trying to reduce flu transmission to ease winter pressures on the NHS.

Children more likely to use drugs than smoke

Children in England aged 11-15 are now more likely to have tried recreational drugs than cigarettes, data showed. Statistics from NHS Digital, based on a survey of 12 000 pupils, showed that 24% had tried recreational drugs at least once, up nine percentage points from 2014. Some 19% of respondents said they had tried cigarettes at least once, in line with 2014.
MEDICINE

Cancer
Emergency bowel cancer diagnosis in third of women
More than a third of women with bowel cancer in England (34%) had it diagnosed after an emergency hospital visit, compared with only 30% of men, although women visit their GP more often, a study found. Researchers from University College London, the London School of Hygiene and Tropical Medicine, and the University of Exeter analysed data on 2799 women and 2946 men with bowel cancer diagnosed in England in 2005-10. The study was presented at the National Cancer Research Institute conference in Liverpool.

Infectious disease
Most TB patients complete independent treatment
Most people complete their treatment for latent TB without direct observation, a study in the Annals of Internal Medicine showed. The phase IV randomised trial assigned 1002 adults in Hong Kong, South Africa, Spain, and the US to receive once weekly isoniazid and rifapentine by direct observation, self administration with monthly monitoring, or self administration with reminders and monitoring. In the US, treatment completion was about 85% in the direct observation group, 78% in the self administration group, and 77% in the self administration with reminders group.

Malaria that killed girl was not acquired in Italy
Tests showed that the strain of Plasmodium falciparum malaria that in September killed a 4 year old girl in Italy—sparkling fears of Italy’s first locally acquired malaria for over 50 years—was identical to that in two children who were in the same hospital after returning from Burkina Faso. Authorities now believe the child, who was receiving diabetes treatment, probably caught malaria from a dirty needle, not a mosquito.

New treatments
UK will fast track new medicines and devices
The government announced a fast track for new medicines and devices to let NHS patients access them up to four years earlier than currently. From next April the “accelerated access pathway” will shorten the time it takes to bring new products on stream for conditions such as cancer, dementia, and diabetes. Each year an expert panel will choose products with the best potential to change lives and cut the time to negotiate evaluation and financial approvals before the NHS can buy them.

NHS pressures
Uncertainty about foreign staff “threatens care”
Continuing uncertainty over recruiting international staff threatens safe, high quality care, NHS Providers warned in a report. It said domestic “quick fixes” were not available and that large falls in overseas staff after Brexit would have a “serious and damaging impact.”

FACETIME
Primary care consultations in the UK last 8 minutes on average, compared with 22.5 minutes in Sweden and under 2 minutes in Pakistan, a study of 67 countries showed [BMJ Open]

WILL THE TAX BE SCRAPPED?
In 2016 Prime Minister David Cameron negotiated an agreement with the European Union which would have enabled the UK to remove the levy on women's sanitary products. A little thing called Brexit happened, which has complicated matters, so plans to scrap the tax have been put on hold.

HOW MUCH TAX DO WOMEN HAVE TO PAY?
Those generous folks at the exchequer apply the lowest rate they can—5%. And, in a bid to appease those who say the tax is unfair, the government gives the money it raises—£12m in 2017-18—to women’s charities.

HOW KIND!
Well, yes—although it has got into trouble over a £250,000 donation to Life Charity, which campaigns against abortion.

OH DEAR...
The government unveiled the list of more than 70 charities that had won funding in March this year but the official announcement chose to focus on charities working in less controversial areas, such as domestic violence and rape. Pro-choice organisations are not on the list of recipients.

SO THE GOVERNMENT HAS AGREED TO WITHDRAW THE AWARD? No—despite an outcry over the grant back in March the government has only just confirmed that it is going to go ahead with the award. However, it has said that the charity cannot use the money for advertising, pregnancy counselling, or education services. Instead the money will be spent on housing, practical help, counselling, emotional support, and life skills training for young pregnant women who are homeless.

ANY OTHER TAMPON RELATED NEWS?
In a landmark announcement, sanitary towel manufacturer Bodyform (as in, whoa-o, Bodyform . . .) has said it is going to use red liquid to demonstrate the absorbency of its products in its adverts, rather than the blue liquid advertisers usually feature. Whether the adverts will depict women rollerskating is unclear.

Cite this as: BMJ 2017;359:j5113

the bmj | 11 November 2017
Ophthalmologists call for right to prescribe bevacizumab for AMD

Ophthalmologists should be able to prescribe the most appropriate treatment for wet age-related macular degeneration, including off-label bevacizumab (Avastin), provided patients give informed consent, the Royal College of Ophthalmologists has said.

The college said that it has long petitioned for a review to find out how bevacizumab could be more widely available in the NHS to treat wet AMD. Using bevacizumab rather than the far more expensive ranibizumab or aflibercept would have “the potential to release funds for much-needed reinvestment into over-stretched hospital eye services,” it said.

Mike Burdon, the college’s president, called for all relevant parties to come together to resolve the issues.

The GMC’s guidance has been called into question after an adviser to the European Court of Justice said that he took the view that off-label drugs can be considered in place of licensed drugs for various reasons, including their price.

“The opinion of the advocate general has raised the profile of the issues again,” said Burdon. “We are calling a meeting of all appropriate bodies, including the regulatory authorities, to discuss this issue.”

Political support
Chi Onwurah, Labour’s shadow minister for industrial strategy, science, and innovation, has also lent her support for doctors to be able to prescribe bevacizumab for eye disease.

Twelve clinical commissioning groups in Cumbria and northeast England, which includes her Newcastle Central constituency, are facing judicial review because they plan to offer bevacizumab to patients with wet AMD.

Onwurah told The BMJ that although she was fully supportive of the drug industry the fact that a cheap drug was safe and effective yet doctors felt unable to use it was a clear example of regulatory failure. “Doctors should be able to prescribe Avastin, given the evidence of safety and effectiveness,” she said.

Onwurah called on relevant bodies to urgently review the law and for the Department of Health to refer bevacizumab to NICE for a technology appraisal of its use in eye conditions.

Deborah Cohen, The BMJ
Cite this as: BMJ 2017;359:j139

How general practices fell victim to banks’ hedge products

The mis-selling of interest rate hedging products to small businesses, including general practices (see p 211), is reminiscent of the scandal over payment protection insurance.

It has been four years since the Financial Conduct Authority investigated interest rate hedging products, or swaps, and found serious flaws in how the banks behaved.

The banks, the FCA said, failed to explain the risks of swaps to customers, who were often not told they would have to pay out if interest rates fell. And neither did the banks sufficiently disclose the deals’ hefty exit costs.

Perhaps the most damming finding was that products were often presented to customers as the only option to secure a loan when other options were available. But although some of the UK’s largest banks, including the Royal Bank of Scotland, agreed to provide “appropriate redress” to small businesses where mis-selling occurred, the FCA did not compel them to do so.

In 2016, the FCA’s oversight of the mis-selling scandal was condemned in the House of Commons, with one MP describing the authority as “weak, toothless, and anaemic.”

Nick Stoop, a founder of Warwick Risk Management, which provides consultancy to affected businesses, has advised 10 medical centres affected by the scandal, around 5% of his clients.

Stoop said that many more practices could have been affected, as the FCA’s review focused on businesses that borrowed £10m or less. “I would be very surprised if the total number of practices affected is not in three figures,” he said.

“Plump” for profit
Stoop said banks had targeted general practices because they were seen as “plump” for profit. This was because the deals tended to be quite large, the loans weren’t repayable for 20 or more years, and the customers were “inexperienced,” he said.

“There is no doubt that doctors were unfairly treated,” said Stoop. “The banks were negligent in the sense that they didn’t explain the risks. It’s your duty when selling a complex financial product to explain the risks in a manner that’s fair, clear, and not misleading.”

Deborah Cohen, The BMJ
Cite this as: BMJ 2017;359:j139

IF I THINK WHAT WE COULD HAVE DONE WITH £3.6M, IT’S JUST SO WRONG
—Nick Nurden

11 November 2017 | the bmj
Practices’ viability is threatened by Capita’s failings, warns BMA

General practice viability is threatened by the failings of Capita, the private company which provides primary care support services, the BMA has warned.

In a letter sent on 30 October to Simon Stevens, chief executive of NHS England, the BMA highlighted what it called Primary Care Services England’s “ongoing issues due to poor delivery” by Capita.

Richard Vautrey, chair of the BMA’s GPs committee, wrote that for more than two years significant issues had been “causing much distress to practices and putting patients at risk.”

In the letter, Vautrey said the BMA was concerned about preparations for Capita to run systems for cervical screening and for GPs’ payments and pensions. He warned, “We have no confidence in Capita’s ability to deliver this service... the consequences of failings will be very serious for practices, potentially affecting their viability.”

Vautrey wrote that some practices had not received trainee grants or had not been reimbursed for trainees’ salaries. This meant “they are having to pay trainees out of already overstretched budgets or trainees are going months without getting paid if the practice cannot cover the shortfall.”

He added that the BMA continued to hear of delays in moving medical records and of missing patient records, “which raises alarming questions about potentially compromising patient safety.”

Vautrey added, “We must receive a comprehensive update on all above-mentioned issues” at a meeting with NHS England scheduled for 9 November.

Capita denied many of the claims, saying it had reimbursed all trainee salaries where possible and it was chasing any outstanding information to make any remaining payments. It added it did not recognise the claims that records in its care were missing or delayed.

A spokesperson said, “This is a major transformation project which inevitably has meant some challenges. This letter does not accurately reflect our involvement and responsibilities in PCSE,” adding that NHS England had “recognised the improvements and significant progress being made across services in 2017.”

In response to the letter, an NHS England spokesperson said, “We are holding Capita’s ‘feet to the fire’ on needed improvements.”

Abi Rimmer, The BMJ

Cite this as: BMJ 2017;359:j123

MORE F2 DOCTORS ARE CHOOSING TO TAKE A CAREER BREAK

Trends in what the UK’s second year foundation (F2) doctors intend to do once they have completed their foundation training is shown in new data from the Department of Health

1 RUN-THROUGH TRAINING The proportion of trainees planning to enter run-through specialty training in the UK has remained relatively static. Just over a third (34%) of trainees in 2011 intended to go into run-through training; the proportion dipped in 2015 to 24%, but in 2016 it returned to almost a third (32.8%).

2 CAREER BREAKS The proportion of doctors who choose to take a career break after completing their foundation training has nearly tripled in five years, rising from 5% in 2011 to 13% in 2016. The proportion of doctors intending to leave medicine has also increased, up from 0.1% in 2011 to 0.6% in 2016.

3 CORE TRAINING Core training seems to have become less popular over the past five years, as just 15% of F2 doctors chose this option in 2016, down from 34% in 2011.

4 SERVICE (NON-TRAINING) ROLES The proportion of doctors intending to take up a service appointment in the UK increased from just 2% in 2011 to 6% in 2014 and to 8% in 2016.

5 LEAVING THE UK The proportion of trainees who choose to undertake their specialty training outside the UK has remained consistently low. However, it fell slightly from 0.8% in 2011 to 0.3% in 2016. The proportion of doctors intending to take up a non-training appointment outside the UK was 7% in 2011; this then fell to 4% in 2014 but had risen to 8% by 2016.

Abi Rimmer, The BMJ

Cite this as: BMJ 2017;359:j5121
Heart stents for stable angina show little benefit

Percutaneous coronary intervention (PCI) is no better than a placebo procedure in improving exercise capacity or symptoms, even in patients with severe coronary stenosis, research has found.

The ORBITA study, published in the Lancet, is the first double blind randomised controlled trial to directly compare stenting with placebo in patients with stable angina who are receiving high quality drug treatment.

Coronary artery stents are life saving in patients with myocardial infarction. For patients with stable coronary artery disease who get pain only on exertion, guidelines recommend antianginal medicine, and PCI is reserved for patients who remain symptomatic.

A common perception is that PCI unquestionably improves angina, but no placebo controlled data support this.

Unblinded trials of PCI have reported an increase in exercise time by 96 seconds more than medical therapy.

Researchers recruited 200 patients with severe (≥70%) single vessel stenosis from five study sites in the UK. Once enrolled, the patients had a six week phase of intensive medical treatment in which antianginal agents were introduced and increased to maximal doses. The patients were then randomly assigned to PCI (105 patients) or a placebo group (95 patients), in which they had an angiogram procedure but did not receive the stent.

Exercise tests were carried out before the procedure and six weeks afterwards. The average

Surgical registrar struck off for refusing to see patients

A surgical registrar who repeatedly refused appeals from junior doctors to attend and examine three deteriorating patients has been struck off by a medical practitioners tribunal in Manchester.

Abayomi Sanusi, who did not attend his hearing, was also found to have lied in a job interview after being dismissed by South Tees NHS Foundation Trust for his clinical failings in three cases at Friargate Hospital in Northallerton, North Yorkshire.

Sanusi was found to have been rude and aggressive to junior doctors and senior nurses who called him asking for help. He failed to examine sick and deteriorating patients when he had a clear duty to do so as the doctor on call. In the case of one patient, a woman who developed signs of septic shock after undergoing laparoscopic hernia repair, Sanusi also recommended furosemide, a diuretic that could have further lowered the patient’s blood pressure, causing organ damage. The junior doctors managing the patient recognised the danger and ignored his instruction.

Another patient was a 92 year old woman who had a painful haematoma in the right calf. The junior doctor who requested Sanusi’s attendance recorded that he “was extremely rude and refused to come and see... He slammed the phone down.”

The tribunal found that Sanusi’s “contention that he had been the subject of victimisation, harassment or malicious allegations,” were baseless, and although no harm to patients had occurred, Sanusi’s lack of insight meant that he “presents an ongoing risk to patients and the public.”

Clare Dyer, The BMJ Cite this as: BMJ 2017;359:j5115

Warfarin is associated with lower cancer incidence, finds study

Use of the anticoagulant warfarin was associated with a lower risk of new cancers in people over 50 in a large observational study published in JAMA Internal Medicine.

Researchers used national registry data to identify 1 256 725 people born from 1924 to 1954 who were living in Norway from 2006 to 2012. Of this cohort, 92 942 (7.4%) were taking warfarin for atrial fibrillation or atrial flutter, cancer risk was lower in people who were taking warfarin, researchers found.

One limitation of the study was that researchers did not collect information on any other drugs or on risk factors that could influence cancer development.

Another potential bias was that no information was included on cancer diagnoses before the start of the study, so some registered
increase in overall exercise time was 28.4 seconds in patients who had PCI and 11.8 seconds in those who had the placebo procedure. However, this difference was not statistically significant. And no significant differences were seen in patients’ reported improvement.

**Improved blood supply**
However, the tests did confirm that stenting considerably relieved narrowing in the coronary artery and improved blood supply to the heart.

Rasha Al-Lamee, of the National Heart and Lung Institute and lead author of the study, said, “Surprisingly, even though the stents improved blood supply, they didn’t provide more relief of symptoms compared with drug treatments, at least in this patient group.”

Jacqui Wise, London
Cite this as: BMJ 2017;359:j5076

**Medical regulators could face merger in government statutory shake-up**

Plans to overhaul the way doctors, nurses, and other healthcare professionals are regulated have had a mixed response.

A key aim of the Department of Health for England’s plans to reform regulation is to ensure that organisations have a “consistent and flexible range of powers that allow them to take a prompt and proportionate approach to concerns about an individual’s fitness to practise.”

To meet that objective, the department has proposed shrinking the number of medical regulators from the current nine to three or four.

Consultation documents were published at the end of October, with a remit for the four UK governments to look into which professions needed statutory regulation.

**Joint working**
Other proposals include promoting more joint working among regulators and having a single database where the public can search the registration status of doctors and other healthcare workers (see box).

It is uncertain how the GMC will be affected, although the health department has said that the case for continuing statutory regulation for some professions, including doctors, was clear.

The GMC has welcomed the chance to discuss reform. It has been calling for some time for legislation that would allow it to modernise its processes. Its chief executive, Charlie Massey, said that he appreciated that the government had recognised that the current legislation was not fit for a 21st century health service.

“As it stands, the legal framework is too prescriptive and makes many of our processes slow, inflexible, and heavy handed. We have done what we can to modernise the way we work, such as reducing the number of unnecessary investigations, but the current law is a roadblock preventing further improvements,” Massey said.

“What we need is legislation that allows us to be swift and efficient in carrying out our primary duty—keeping patients safe—while reducing the burden on doctors.”

**Proposals not welcome**
However, the proposal for merging regulators has not been welcomed.

Although the BMA said it would support reasonable changes to medical regulation, Chaand Nagpaul, chair of the association, said that “professional regulation of doctors should continue to be separate from the regulation of other professions and providers.”

Nagpaul said, “It is vitally important that the different complexities of each profession, which have numerous training structures, career routes, and healthcare responsibilities, are taken into account.”

The medical indemnifier the Medical Protection Society (MPS) also warned against an amalgamation of the medical regulators.

Pallavi Bradshaw, senior medicolegal adviser at MPS, said, “We will be reviewing the detail in this consultation carefully—an amalgamation exercise which could result in the specific expertise of each profession’s regulator being lost would be concerning.” She added, “Any new regulators, replacing the existing nine, would need to be able to distinguish between the hugely differing roles within the many professions they would oversee.”

The consultation closes on 23 January 2018.

Abi Rimmer, The BMJ
Cite this as: BMJ 2017;359:j5131

Jacqui Wise, London
Cite this as: BMJ 2017;359:j5129

Jacqui Wise, London
Cite this as: BMJ 2017;359:j5076

**KEY PROPOSALS**

- Cutting the number of organisations from nine to three or four
- Speeding up decisions about poor performance and misconduct
- Establishing a shared search engine system that would cover all registered healthcare professionals, to “make it easier for patients, the public, and employers to access details about that professional’s registration”
- Setting up a single adjudicator responsible for all fitness to practise decisions, built on the GMC’s Medical Practitioners Tribunal Service. This would “provide greater consistency of decision making”
- Establishing a single organisation conducting back office functions for all the regulators
- Improving professionalism by checking that members’ skills are up to date
- Promoting joint working between regulators

The BMJ | 11 November 2017
“Do not do anything. Do not go for a morning walk. Do not go out”
The Indian Medical Association last week declared a public health emergency in Delhi as air pollution reached “severe” levels and smog engulfed the city. The association advised residents to stay indoors and asked for schools to be closed as the average air quality index in the capital hit 396 (very poor). The level of the most toxic fine pollutants known as PM$_{2.5}$ reportedly reached 703 μg/m$^3$—over 300 is classed as hazardous—leaving visibility at less than 50 metres.

In a video posted on Facebook, K K Aggarwal, the president of the IMA and of the Heart Care Foundation of India, warned even healthy people not to take any exercise at all while the pollution was so high. “Any type of exercise is not healthy,” he said. “Do not do anything. Do not go for a morning walk. Do not go out.”

He also pledged the IMA’s support for the national My Right to Breathe campaign and its fight for the government to pass a clean air act. “Let’s all fight for clean air. Let’s make sure that our air is pure so that we can all live a normal life.”

Alison Shepherd, The BMJ
Cite this as: BMJ 2017;359: j5164
STPs

The partnerships charged with overhauling services will flounder without clinical scrutiny, say hospital doctors—the very things the new groups most lack, according to new research. Jennifer Richardson reports

The latest vehicle for overhauling NHS services is either “progress on the road to better care” or “destined to fail,” senior hospital doctors say. Either “an opportunity to introduce major improvements to the quality and effectiveness of NHS services” or “a fundamental threat to services.”

A Hospital Consultants and Specialists Association (HCSA) report published on 9 November finds little prospect of middle ground for sustainability and transformation partnerships (STPs), the 44 regional collaborations of NHS organisations charged with improving care and financial stability by 2021.

There is still opportunity and time, says the HCSA, a professional body and trade union for hospital doctors, to ensure that the positive of the two extremes prevails. However, that will depend extensively on one thing largely missing so far: clinician input.

The report is damning on this front. In a survey emailed to 2429 members in England with 454 (19%) respondents, 95% thought they had not been consulted on or had sufficient involvement in STPs. This lack of clinical scrutiny is “condemning [STPs] to be another damaging and short lived reorganisation,” says HCSA chief executive and general secretary, Eddie Saville.

Some respondents said they had not heard of STPs before the survey despite, as the HCSA points out, the partnerships representing an important change in the way the NHS in England will plan and run services. Others thought that what clinician involvement existed was “window dressing,” with “no intention of genuine consultation.” This reflects the finding that 96% of respondents believe “STPs are not being created in a transparent and open manner.”

The HCSA concludes that lack of engagement has led hospital doctors to be, at best, sceptical that STPs will

What hospital doctors think about:

- The impact STPs will have on patient care
- STPs being a measure to introduce NHS cuts
- STPs resulting in job cuts and further understaffing

Source: STPs—Destined to fail or the road to better care? HCSA, November 2017
improve care and, at worst, suspicious that they are a front for cuts and privatisation. One doctor told the survey: "Clinician involvement seems to be very superficial so that NHS England can say it is clinician-led. [The] reality is, this is driven by financial pressures and political agendas."

Over three fifths (62%) of respondents believe STPs will have a “negative impact” on care—yet only 37% are actively against them. Just over half (51%) said they were “not sure” whether they support STPs, with 12% expressing support. Diabetes and endocrinology consultant Partha Kar tells The BMJ that this reflects clinician apathy. “Many people have a bit of a ‘meh’ approach. It’s seen as a managerial tinkering with the system. It’s got a lot of potential, but at the moment it’s wasting it.”

Sense of frustration
This is a view also expressed by the HCSA, whose report conveys a strong sense of frustration at a potential missed opportunity. It concludes that the 51% of “not sures” represent an open goal to win over clinicians and “salvage the potential benefits of STPs—joined-up care and a positive transformation of services.”

As well as “hardwiring” clinician involvement into STPs by making it a requirement and placing greater responsibility on STP leaders, the HCSA calls for full financial, impact, and risk analyses of each STP plan, to determine the funding and timescales needed to realise them. NHS England’s existing “STP progress dashboard” is, “a rather rudimentary progress review” and insufficient for this, the HCSA tells The BMJ.

A more realistic target than the five years to 2021 would be to implement the plans from 2020, the HCSA proposes, but with staggered implementation across the country taking “perhaps well over a decade.”

“The process is too fast, too vague, [and] underfunded,” Saville concludes. “Despite this, there is still an opportunity to turn things around. Let’s slow this down…and really look at the resources required to avoid damaging service cuts.”

Jennifer Richardson, features editor, The BMJ

Cite this as: BMJ 2017;359:j5130

AN STP LEAD AND HOSPITAL DOCTORS RESPOND

Paul Donaldson
consultant microbiologist, and HCSA executive member
I have had essentially no involvement with the local STP, other than updates and a few news-like items from the trust. These focus on how they think they are progressing. Invitations to attend “listening” meetings have occasionally been made. I have not been able to attend because of clinical commitments, but reports from others are that they are essentially window dressing and any comments made are unlikely to influence the programme.

The clinical consultations that seem to have taken place are with senior medical managers such as medical directors; those with such appointments are not always likely to reflect concerns of other medical staff.

The local negotiating committee, of which I am a member, asked for more specific information and involvement. This came to nothing. Information is necessarily a bad thing.

Limited involvement and consultation lead to suspicion

Rob Webster
chief executive, South West Yorkshire Partnership NHS Foundation Trust, and West Yorkshire and Harrogate STP lead
Providing the time and infrastructure to ensure clinicians can lead and engage in change is a challenge in the context of service pressures. But there is no alternative, and we are seeking to engage as many people as we can.

We have some strong examples, and there are areas where there is more to do. For example, an acute provider collaboration project is looking at tackling variation in care provision and quality between two trusts. Clinical engagement workshops have already taken place to agree areas of focus in gastroenterology.

Clinicians in primary, secondary, and specialist care are involved at every level in the work of our Cancer Alliance; how we can further improve stroke care across the area is being carried out with leading consultants and other healthcare professionals.

The HCSA report sometimes falls into the trap of blaming STPs for things that have been decided elsewhere. As STP leader, I did not decide how much resource would be given to the NHS or local government, for example. I would like us to have more control over monies, so we can put them into the hands of clinical leaders to redesign care.

I share many of the observations in the report on workforce, finance, accountability, and the pace of change. We need to ensure hospital doctors and other staff are involved and have clinical networks where they feel they have control and influence over the choices we have to make. Without them we don’t have an STP or credible plan of action.

Andrew Goddard
registrar, Royal College of Physicians, and consultant gastroenterologist, Royal Derby Hospital
We need to try to take a more holistic view of health and social care, and the STPs are the first step in that process. This will in the end shift funding from secondary to primary care but that is not necessarily a bad thing.

It is clear, though, that the savings envisaged through bed reconfiguration are unachievable in the time frame set out by most STPs, let alone the aspirational reductions in outpatient attendances and emergency department attendances and admissions.

As the HCSA report says, the Achilles’ heel of all of the STPs is workforce. Every part of the system is struggling. Some STPs are looking at ways to improve local recruitment. This is admirable but will take a lot of effort to achieve.

Given the undersupply in carer, nursing, and medical workforces (let alone the worries of a world post-Brexit) it is hard to see how STPs will work. Having said that, the direction and destination is the right one and STPs are currently the only game in town. We as clinicians need to get playing that game.

Getting STPs to achieve just some of their aims is like climbing a mountain in flip-flops. In good weather it is just about achievable, but the NHS climate is currently hostile. Clinicians are the mountain boots for STPs. Without us it is all going to go horribly wrong.

The RCP has produced a video to help members engage with STPs.
https://www.youtube.com/watch?v=xzti2ZPPwzg

“Engaging clinicians is a challenge but if we don’t we have nothing”

“STPs are the only game in town and clinicians need to get playing”

“The hands of clinical leaders to redesign care. We need to ensure hospital doctors and other staff are involved and have clinical networks where they feel they have control and influence over the choices we have to make. Without them we don’t have an STP or credible plan of action.”

“Engaging clinicians is a challenge but if we don’t we have nothing”

“STPs are the only game in town and clinicians need to get playing”
Trusts speed date with refugee doctors

In a large room in Stockton-on-Tees, NHS doctors sit behind individual tables chatting to one of 12 refugees. Every five minutes the refugees move round until everyone has met. These are not mini health consultations or asylum claim interviews. The refugees are qualified health professionals in need of a mentor to help them start practising in the NHS. “This is how we find our mentors,” says Jane Metcalf, deputy medical director at North Tees and Hartlepool NHS Foundation Trust. “We speed date them.”

Once paired up, the refugees have a sympathetic insider to turn to as they take the English language test and find a clinical placement to help them pass the Professional and Linguistic Assessments Board (PLAB) test of medical skills and knowledge, without which they cannot apply for a job. Most of the volunteer mentors are doctors from abroad who know how daunting the system can be.

In 2015, Metcalf and a colleague at Health Education North East started to work with the charity Investing in People and Culture. Together they created the resettlement programme for overseas doctors. In the first year they signed up 12 people (11 doctors and a pharmacist) from some of the most troubled countries in the world, two of whom are now on clinical placements. The rest are still working to pass their exams. The refugees have varying backgrounds: some with 20 years of experience, some fresh out of medical school, some who have escaped wars, and others who have been delivering pizza or driving taxis in the UK for years.

“We are refugees,” Eli, a primary care doctor from the Democratic Republic of Congo, told the BBC in August. “But we are doctors too. Before this programme we had no road, no route. Now we have hope again and can give something back.”

**Back to basics**

“They all have to go back to basics,” says Metcalf. “For those who reached a senior level in their own country, it can be really tough.”

The North Tees project, which has just signed up its second cohort, is not the first. Similar programmes, also with Health Education England (HEE) funding, have been running in London and Manchester for more than a decade.

Between September 2014 and March 2016, 108 healthcare professionals joined the Building Bridges programme, a collaboration between three charities—the Refugee Council, the Refugee Assessment and Guidance Unit, and Glowing Results—two London hospital trusts, general practices and other healthcare centres. By 2017, at least 62 were employed, but the scheme has found that mature refugees who had not practised for some time take an average of seven years to get a job.

In Manchester, Reache North West (reache.wordpress.com) has helped more than 200 refugees to find work in collaboration with Salford Royal NHS Foundation Trust. Metcalf says she has had inquiries from as far away as London and Kent, but also from Leeds and Liverpool, keen to set up similar programmes. “There is a real unmet need,” she says. “I don’t think it’s very coordinated from Health Education England, which is where the coordination needs to come from.”

The BMA’s Refugee Doctor Initiative provides a free package of benefits for refugees working towards GMC registration and provides contact details for organisations that can help. And NHS Employers, which negotiates contracts with healthcare staff on behalf of the government, has hosted the refugee healthcare professionals programme, arguing that once in the NHS, refugees tend to remain for the rest of their career.

**Cost effective for the NHS**

Supporting a qualified refugee to pass exams and find a clinical placement costs very little—£5000 according to Metcalf, compared with £250 000 to train a doctor from scratch. In London, HEE spends £20 000 for each refugee on the clinical apprenticeship placement scheme, which provides six month foundation posts, usually in general or emergency medicine or general surgery.

Given forecasts of staff shortages, utilising highly qualified refugees in the UK is not only humanitarian but makes financial sense too.

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On 27 October, the 50th anniversary of the Abortion Act, more than 100 MPs put their names to a letter urging the government to introduce buffer zones to prevent anti-abortion activity outside women’s and reproductive health clinics.

It follows a groundbreaking vote by Ealing council, in west London, to explore the possibility of introducing a public space protection order to prevent activists picketing clients and staff outside the local Marie Stopes reproductive health and abortion clinic.

These moves are welcomed by doctors who provide abortion care, but some doctors argue that such restrictions on the activities of anti-abortion pressure groups amount to a ban on free speech.

Escalation?
The British Pregnancy Advisory Service, which runs more than 40 abortion clinics and sexual health centres in England, Wales, and Scotland, has campaigned for the introduction of buffer zones since 2014. It says anti-abortion activists carry large banners of dismembered fetuses, distribute leaflets containing misleading information about abortion, and follow and question women as they enter or leave the clinics. It claims that anti-abortion activity is escalating in the UK.

Caroline Gazet, a surgeon and deputy medical director at Marie Stopes, a reproductive health and abortion service provider, agrees. “I have provided abortion care for 10 years and I have definitely noticed that over the past few years there are more protesters outside clinics, particularly at times such as Advent and Christmas,” she says.

Wendy Savage, a retired obstetrician and gynaecologist, says that although there have been violent incidents outside clinics in America, so far nothing similar has occurred in the UK. Savage, spokesperson for Doctors for a Woman’s Choice on Abortion and a voting member of the BMA Council, does not believe that protests would turn ugly here because we have a different cultural tradition.

Buffer zones have successfully been introduced by two provinces in Canada: Ontario and British Columbia. However, in 2014 the US Supreme Court quashed a statute in Massachusetts that had created a no entry zone outside abortion clinics, on the grounds that it violated activists’ rights to freedom of speech.

Should doctors support tougher restrictions on anti-abortion protests?
The idea of buffer zones to prevent demonstrating and picketing around clinics is gaining traction. Francesca Robinson reports on the thoughts of clinicians on both sides of the fence.

No other option
Savage argues that the only realistic alternative to buffer zones is siting services entirely in NHS hospitals, which protesters would not be allowed to enter.

The BMA has not discussed the idea of introducing buffer zones, Savage says, but she believes that most doctors would support women being able to receive healthcare without harassment. “An individual should be free to speak on a public platform but not to harass women going into a health facility,” she says.

However, retired GP Mark Houghton argues a ban on anti-abortionists picketing clinics would be “way over the top.” “From what I
have seen in the debate around this issue, the actions of the protestors probably wouldn't fulfil the legal criteria for harassment,” says Houghton, who has recently published a book, Pregnancy and Abortion—Your Choice. “These picketers aren’t hostile, and they don’t give out moral advice but offer practical support to pregnant women such as financial help, baby care, or help with housing. I don’t see any evidence that protestors act in a degrading or hostile way towards women outside clinics.

“British people really value free speech, and there would have to be a very big reason for curtailing it.”

Workforce worries

The Royal College of Obstetricians and Gynaecologists (RCOG)—whose council recently voted to support removing criminal sanctions associated with abortion for patients and healthcare professionals—has for several years supported the introduction of buffer zones to limit anti-abortion activity. It argues that limiting the ability to interfere with women as they try to access a lawful medical service in confidence does not represent an undue restriction on existing freedoms.

RCOG president, Lesley Regan, says members have experienced picketers harassing women in various ways. These include filming people approaching clinics, giving unsolicited advice that is contrary to that provided by doctors, and providing erroneous information about clinical risks, such as linking abortion with breast cancer.

“The RCOG appreciates that there is a wide range of views about abortion, and that there must be opportunities for these diverse and strongly held views to be heard. However, intimidating staff who are providing a lawful and necessary service, and approaching women accessing these services who may already feel vulnerable, are unacceptable ways to promote anti-abortion views,” she says.

This potential deterrent against practising in abortion care is part of the college’s wider concerns about the future and welfare of the abortion workforce, Regan adds. She claims the shift towards provision of abortion services by the independent sector has led to a reduction in the training opportunities and placements available to doctors working in the NHS. This has resulted in fewer doctors with the requisite skills to deliver abortion care to women across the UK.

“There is also an overall feeling that abortion care has low prestige in the NHS, and, as a result, staff working in this field report feeling undervalued and isolated, rather than feeling as though their work is regarded as an essential part of delivering improvements to women’s health,” Regan says.

“This sense of low prestige for the workforce is exacerbated by the intimidating tactics of anti-abortion groups outside clinics as well as negative press coverage around abortion.”

The right thing

Gazet says the presence of protestors outside clinics does not stop doctors doing abortions because those who choose this field are passionate about their work. “They believe it is the right thing to do for women’s health. If you go into abortion care it is not a decision you make lightly,” she says (see Personal View, right).

Responding to the MPs’ letter, the Home Office says: “This government is absolutely clear that abortion protesters outside clinics as well as commentary assume that we are clients and are having an abortion. The intimidation can range from people sitting outside quite quietly with leaflets and banners, to trying to put rosaries or leaflets with pictures of fetuses into your hand or to bar your way as you go in.

“I went to Birmingham last week to do some teaching and somebody tried to stand in front of my car and put a leaflet on the windscreen as I tried to drive into the premises. The same thing happened as I was leaving. It’s very worrying as there is the potential for an accident. “The protesters are not aggressive in the physical sense; it’s more that they put emotional pressure on women. It’s quite intimidating and it’s certainly not pleasant. If you put yourself in the clients’ shoes it is just another awful thing they have to endure before they can get the treatment they need.

“The activities of the picketers do sometimes upset our clients. The front of house staff will comfort them and escort them in if necessary, but if a woman is still shaken by the time she gets to the treatment room then we would probably postpone the procedure in order to make sure that it is what she really wants.

“It is hard for staff who work in these clinics to have to battle through this harassment every day, and it’s unnecessary. However, the protests won’t intimidate me or any other doctors and nurses from doing this job because those of us who perform abortions are all very passionate about our work and feel we provide an important and necessary service for women.”

“Anti-abortionists “will not intimidate me”

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Lessons in planning from mass casualty events

Plan for long term disruption and enduring effects on healthcare staff

The NHS in England has faced an unprecedented number of major incidents this year: the Westminster Bridge terrorist attack (22 March), the Manchester Arena bombing (22 May), the London Bridge attack (3 June), the Grenfell Tower fire (14 June), and terrorist attacks at Finsbury Park mosque (19 June) and Parsons Green underground station (15 September). These events tested the country’s major trauma systems. Each incident posed new challenges, with different threats, resulting in different injuries. System learning is critical: debriefing and sharing information so lessons can be rapidly assimilated. In England, “hot” debriefs took place within two weeks and “cold” multiagency debriefs after four weeks, with post-incident reporting beyond six weeks. Here, we share some of that learning.

Emergency planning, resilience, and response commonly gives primacy to the initial stages of managing a major incident—first response, treatment on scene, triage, distribution of casualties, hospital reception, repeat triage, resuscitation, primary management, and command and control structures. These are rehearsed in desktop and simulation exercises, and both the Manchester and London teams found these valuable in testing plans and informing policy and practice during incidents. However, it has become clear the effect on hospitals and staff endures well beyond the first 24 hours.

**Longer term demands**

Clinical first responses are centred on resuscitation and damage control surgery for patients with immediately life and limb threatening problems. The secondary procedures that follow in subsequent days are often resource intensive. More than 350 hours of extra surgery were required in the week after the Manchester attack. All trauma patients require a repeat, top-to-toe examination (tertiary survey), re-review of imaging and further investigations to reveal occult injuries. Rehabilitation begins early and requires intensive multisystem input from medical staff and allied professionals such as physiotherapists and occupational therapists. As the investigation and management of complex injuries proceeds, hospitals should not underestimate the need for operating rooms, blood products and other consumables, intensive care provision, and coordinated multidisciplinary intervention. Logistic demands continue, supplies must be restocked, equipment decontaminated, escalation areas returned to their original purpose, and recording systems organised.

Mass casualty events have long term implications for primary care and community services. Patients with severe physical injuries require prolonged treatment, rehabilitation, and support. Those with blast injuries may have auditory and ophthalmic injuries and occult concussion, requiring screening and follow-up. Patients at risk of bloodborne virus infection need counselling, post-exposure prophylaxis, and follow-up by public health teams.

Traumatic incidents impose profound psychological stress on patients, their families, the bereaved, witnesses, and the wider community. Individuals from all these groups may develop mental health complications. Targeted screening programmes are required to identify those at risk and direct them to professional help.

**Support for staff**

Perhaps the clearest lesson to emerge is that the physical and psychological effects on staff at receiving hospitals are severe, underreported, and underappreciated. Healthcare teams often witness death and life changing injuries against a backdrop of exhaustion. They are required to function at a high level in an extremely high pressure situation. Staff need time to recuperate after the extraordinary demands placed on them.

London Ambulance Service alone provided psychological screening and support to 1000 members of staff responding to this year’s events. The psychological needs of staff should be recognised as an important reason, in addition to ongoing demands on physical resources, for a delay before “normal” elective work resumes. Commissioners and providers must reach a mutual understanding that recognises the need for a recovery period “until all disruption has been rectified, demands on services have returned to normal, and the physical and psychosocial needs of those involved have been met.”

Hospitals should plan for effects lasting weeks or even months. Demands on resources remain high, including physical and psychological demands on staff. Supporting them is a critical component of medium and long term planning, along with a recognition of the effect their experiences will have on their capacity to return to “business as usual.”

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EDITORIAL

Reassurance on HRT for many healthy women

But individual assessment of risk benefit balance remains essential

Many women remain fearful of using menopause hormone therapy because of concerns about the risk of heart attack, stroke, and breast cancer. These concerns were prompted by the two Women’s Health Initiative (WHI) clinical trials that were stopped early in 2002 and 2004.

In the first trial women who took conjugated equine oestrogen and medroxyprogesterone had an increased incidence of heart attacks, strokes, and breast cancer compared with those taking placebo. The second trial in women with a hysterectomy found an increased incidence of stroke and venous thromboembolism in those treated with conjugated equine oestrogen compared with the placebo group but no increased risk of breast cancer. Neither trial reported a rise in total mortality among actively treated women.

Shock waves

The results sent shock waves through healthcare communities. Prescriptions for hormone therapy, once the most commonly prescribed medication, fell more than 70% over the following years in the US.

Now Manson and colleagues have reported all cause and cause specific mortality among WHI participants after 18 years of follow-up, comprising five to seven years of treatment during the two trials plus an extra 12 years of follow-up after the trials ended. Hormone therapy was not associated with an increase in all cause mortality (hazard ratio 0.99; 95% CI 0.94 to 1.03), cardiovascular mortality (1.00; 0.92 to 1.08), total cancer mortality (1.03; 0.95 to 1.12), or other mortality (0.95; 0.88 to 1.02) compared with placebo in the two trials.

The WHI trials were primary prevention trials in mostly white women (80%) to evaluate if hormone therapy prevented cardiovascular and other chronic diseases. By design, they did not include women with severe vasomotor symptoms because this would reduce adherence, and only 12.5% of participants were aged 50 to 54 years—around the age of menopause. The average age of starting hormone therapy was 63.

Several WHI analyses have evaluated the timing of hormone therapy, finding a trend to lower risk of cardiovascular disease associated with treatment at 50-59 years, but results have been limited by low power. In Manson and colleagues’ new, age group analyses, women treated at age 50-59 had a greater reduction in all cause mortality than women treated at 70-79 both during treatment (hazard ratio 0.61; 0.43 to 0.87) and after 18 years’ follow-up (0.87; 0.76 to 1.00). These findings are important because they align with current guidelines that support the use of hormone therapy by healthy and recently menopausal women for symptom control.

Most notable in the new analyses are differences in mortality from breast cancer. During the original trials, breast cancer risk was increased in the oestrogen plus progestin arm (1.25; 1.07 to 1.46) but not in the oestrogen only arm (0.77; 0.57 to 1.01). Ten years after the trials ended, women who took only oestrogen had a significantly lower risk of breast cancer than the placebo group (0.77; 0.62 to 0.95). This difference can now include breast cancer mortality. After 18 years follow-up, women originally randomised to oestrogen alone had significantly lower breast cancer mortality than those randomised to placebo (0.55; 0.33 to 0.92). But women randomised to oestrogen plus progestin had a non-significant increase in risk (1.44; 0.97 to 2.15).

More research is needed to understand these differences, and to identify the role of medroxyprogesterone in risk of breast cancer.

In practice

The new findings are relevant to a short duration of use, five to seven years, and should reassure healthy women considering hormone therapy for menopausal symptoms. But they should not replace guidelines that continue to stress the importance of individualised risk assessment. Use of hormone therapy for five years with oestrogen plus medroxyprogesterone increases women’s risk of breast cancer, while oestrogen alone does not have the same risk and may now be associated with reduced mortality from breast cancer in the longer term. It remains the case that hormone therapy is not intended to prevent cardiovascular disease or death.

The unexpected finding that hormone therapy did not prevent cardiovascular disease allowed for criticism of the dose, formulation, and route of delivery used in the trial and prompted evaluations of doses and modes of delivery. Research should now focus on determining if the results for all cause and cause specific mortality hold true for different doses, formulations, and routes of delivery.

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