this week

HALF OF EU DOCTORS MAY QUIT UK page 254 • **FAILURE OF NHS REFORMS** • page 256

GPs spark legal fight over app service

GPs' representatives are to seek legal advice in a bid to challenge the rollout of a service offering "virtual" GP consultations to patients via smartphone.

An emergency motion passed by England's local medical committees has demanded that the BMA's General Practitioners Committee seek "urgent legal advice regarding the options available and the potential for a judicial review" to challenge the introduction of the GP at Hand service, being piloted in west London.

The motion, passed at last week's LMC conference, called on the GPC to seek urgent negotiations with the health secretary, Jeremy Hunt, to compensate practices for the loss of income they will incur if patients switch to services such as GP at Hand.

The service, launched by a group of GPs and a private healthcare company, Babylon, offers NHS patients the chance to receive "virtual" consultations 24 hours a day through a video link on their smartphones. But the scheme has been accused of "cherry picking" healthy, younger patients, as its website suggests that the service may not be appropriate for older people and patients with more complex health needs.

Patients first have to de-register at their existing practice, which GPs argue risks destabilising practices by leaving them with the most vulnerable patients.

Susie Bayley, of Derbyshire LMC, who proposed the motion, said it was "unacceptable" for the NHS to permit the rollout of a "morally questionable" service, which could "lead to huge inequity."

But Mobasher Butt, a GP and medical director of Babylon Health, said that the vote sent out "a poor message" to patients. He said that critics had misunderstood what the service offered and insisted that it was not excluding specific groups of patients.

Butt told *The BMJ*, "This is an NHS service available for everyone. NHS England makes it very clear that any practice registering patients outside of the practice area should decide if it's clinically appropriate for that patient. It provided a list of situations where it might be helpful for a patient to have a discussion with us beforehand. It's not a list of exclusions. To suggest this cherry picking is completely disingenuous."

Jane Barnacle, director of patients and information at NHS England in London, said, "GP practices are right to carefully test innovative new technologies."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;359:j5292

COMMENT, p 273

Susie Bayley, a Derbyshire GP, called the GP at Hand service "morally questionable"

LATEST ONLINE

- Father is banned from visiting brain damaged son in NHS hospital
- Air pollution, diet, and obesity pose growing threats to health in India
- US voters back Obamacare in local and state elections

SEVEN DAYS IN

Half of EEA doctors are considering leaving UK

Almost half of doctors from other European Economic Area countries working in the UK are considering leaving in the wake of the EU referendum result, with almost a fifth having already made solid plans to relocate, a BMA survey has found.

Healthcare leaders urged the government to offer certainty to the estimated 12 000 EEA doctors working in the NHS, 7.7% of the workforce. The BMA said that recruitment from elsewhere in Europe had been a crucial means of dealing with staff shortages and warned that NHS services would struggle to cope with departure of staff on such a scale.

The poll, conducted between September and November, received responses from 1720 EEA doctors. Forty five per cent said that they were considering leaving the UK. A further 29% said that they are unsure. Of those considering leaving, 39% said that they had made plans to leave. The top three reasons cited were Brexit, a negative attitude towards people from other EU countries, and uncertainty over future immigration rules.

Andrew Dearden, the BMA's treasurer, said, "That so many EU doctors are actively planning to leave the UK is a cause for real concern. Without them our health service would not be able to cope. We need an end to the uncertainty and insecurity."

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2017;359:j5273**

Maternal health

Spontaneous labours fall in England

The proportion of pregnant women who have a spontaneous labour decreased from 57.4% in 2015-16 to 55.1% in 2016-17, NHS Digital reported. The proportion of caesareans done before the onset of labour increased from 14.7% to 15.5%, and induced labours rose from 27.9% to 29.4%. Further data showed that anaesthetic or analgesic use before or during delivery increased from 59.4% of deliveries in 2015-16 to 60.0% in 2016-17, but this was lower than 10 years ago (68.6%).

Pre-pregnancy weight links to illness or death

Being underweight or overweight before becoming pregnant is associated with a small but significant increase in severe illness, including eclampsia and thromboembolism, or death during pregnancy, a large US study reported in *JAMA*. Data on more than 700 000 women showed that those who were underweight before pregnancy had a 20% higher risk of severe maternal morbidity or mortality than women of normal weight. Overweight women had a 10% higher risk of such complications, and the risk was 40% higher in severely obese women.

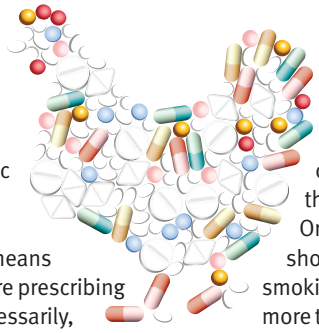
Antibiotics

WHO advises farmers against routine antibiotics

The World Health Organization issued guidelines recommending that farmers and the food industry stop using antibiotics routinely in healthy animals, as part of efforts to reduce the spread of antibiotic resistance. It warned that nearly 80% of total consumption of medically important antibiotics in some countries is in the animal sector, largely to promote growth in healthy animals. A systematic review informing the recommendations, published in *Lancet Planetary Health*, found that interventions restricting antibiotic use in food-producing animals reduced antibiotic resistant bacteria in these animals by as much as 39%.

Patients request antibiotics less often

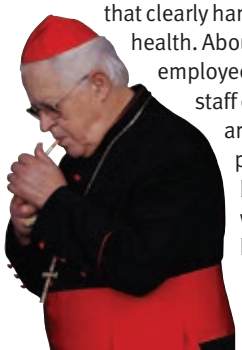
Patients are not asking GPs for antibiotics as frequently as in previous years, research suggested. But, while UK GPs are reducing antibiotic prescriptions, a lack of access to diagnostic tools means that over a third are prescribing antibiotics unnecessarily, said two polls commissioned by the Longitude Prize. The prize fund was launched in 2014 with a challenge to develop a point-of-care test to detect and understand infections, to help ensure that the right antibiotics are used at the right time.



Public health

Vatican to ban sale of cigarettes from 2018

The sale of cigarettes will be banned inside the Vatican from next year, after Pope Francis said that the Holy See could not cooperate with a practice that clearly harmed people's health. About 5000 employees and retired staff of the Vatican are currently permitted to buy cigarettes, which are heavily taxed in Italy, at a discount rate. A spokesman for the pope cited figures from the World Health Organization showing that smoking accounts for more than seven million deaths a year worldwide.



Assisted dying

Euthanasia rises by two thirds in Netherlands

The number of people dying by euthanasia in the Netherlands has increased by 67% in the past five years. Cases are set to exceed 7000 this year, up from 4188 people in 2012 who met the criterion set out in 2002 legislation: a voluntary and well considered request in the context of unbearable suffering where there is no prospect of improvement and no alternative remedy. Steven Pleiter, director of the country's only clinic specialising in euthanasia, said that the increase represented the end of "the taboo" on killing patients who want to die, and he expects numbers to rise further in the next few years.

MEDICINE

Budget

NHS "needs £4bn boost" in budget to protect care

The government must commit at least £4bn more to the NHS in the autumn budget to prevent patient care from worsening next year, three leading healthcare think tanks warned. In a joint analysis issued ahead of the 22 November budget the Health Foundation, the King's Fund, and the Nuffield Trust estimated that current government spending plans fall well short of what the NHS needs. They warned that patients will face longer waits for treatment, more service rationing, and deteriorating care.

Health think tanks say patient care will deteriorate if the NHS does not receive more funding

Devolved nations

New "historic" contract for Scottish GPs

GPs in Scotland are being asked to vote on a new contract designed to cut workload, reduce responsibility for practice premises, and offer partners a guaranteed minimum income. The proposed contract, the result of months of negotiation between the BMA and the Scottish health department, has been described by doctors' leaders as "historic." It aims to reduce pressure on GPs and tackle recruitment and retention problems.

Healthcare reform

Patients' views were "sidelined" in STP launch

Public engagement with NHS reform went into "paralysis" when plans for sustainability and transformation partnerships (STPs) were launched in December 2015, said the deputy director of Healthwatch England, the organisation set up to represent NHS patients' views. Neil Tester, speaking at a King's Fund event, said that communications between NHS bosses and the public went into "lockdown" at local level as STP plans were rolled out.

Whitehall

Stephen Powis named as medical director

Stephen Powis, currently medical director of the Royal Free Hospital in London, was appointed medical director of NHS England. He will take over from Bruce Keogh at the end of the year. Powis was previously chair of the Association of UK Hospitals' medical directors group and a board member of Medical Education England. He said, "My task is to ensure we remain relentlessly focused on health improvement and achieving the best possible outcomes for patients."

Ex-GSK chief to be UK chief scientific adviser

Patrick Vallance (below), president of research and development at GlaxoSmithKline, was named as the government's chief scientific adviser. Vallance, who has worked for GSK since 2006, will take up the role next April. A physician and clinical pharmacologist, he was chair of medicine at University College London. He replaces Chris Witty, who has served in an interim role since September 2017 after the departure of Mark Walport.

Cite this as: *BMJ* 2017;359:j5283

OBESITY

In 2015, **26.9%** of the UK population had a body mass index of 30 or above. The UK has the highest obesity levels of any country in Western Europe: only five of the 35 nations in the Organisation for Economic Cooperation and Development had higher obesity levels than the UK *[OECD]*

SIXTY SECONDS ON . . . THE CIRCADIAN RHYTHM

IS THIS ANOTHER YOUTH CRAZE, LIKE THE HARLEM SHUFFLE?

I think you mean the Harlem shake. But no—it's not a dance. The circadian rhythm is what you and I call the body clock, and scientists are starting to recognise its importance to health.

SUCH AS?

A recent Medical Research Council study found that cuts and burns sustained during the day heal 60% faster than those sustained at night. Wounds that occurred between 8 pm and 8 am were classed as 95% healed after an average of 28 days, compared with an average of 17 days for daytime wounds. Researchers found that fibroblasts rushed to the site of the wound more quickly during the day than at night.

IS THAT IT?

No—another recent study found that patients who have heart surgery in the afternoon have a 50% lower risk of a major cardiac event postoperatively than those who have surgery in the morning. Of 298 patients in the study, 28 operated on in the afternoon had a major event, compared with 54 of those undergoing morning surgery.

ARE SURGEONS PERKIER AFTER LUNCH?

One commentator, John O'Neill, from the MRC Laboratory of Molecular Biology, said as the study was small, involving just two surgeons, their chronotype could affect outcomes.

THEIR CHRONOTYPE?

Whether they are a morning lark or a night owl. According to a new book, *Why We Sleep*, by neuroscientist Matthew Walker, larks and owls operate on different circadian rhythms and there is little we can do to change this. Owls do worse, generally, because work and school favour early risers.

I'M AN OWL. DO YOU THINK MY BOSS MIGHT LET ME START AT 10.30 AM?

I'm not sure about that. But you could tell your boss about Walker's warning that those who don't get enough sleep are more likely to be fat, depressed, and poor, get cancer and Alzheimer's, and die in a car crash.

I SUPPOSE I COULD GO TO BED EARLIER

And turn your phone off, keep your room cool, avoid alcohol, and establish a sleep routine.

Anne Gulland, London Cite this as: *BMJ* 2017;359:j5243

Lansley NHS reform "failed to deliver"

"The scheme was based on a false premise. It is not very surprising the reforms didn't have the effects expected"
Nigel Edwards, Nuffield Trust

The government's major reorganisation of the NHS in England in 2012 failed to reduce admissions to hospital, shows a new study that tracked the effects of the changes on hospital workloads. Furthermore, it found a rise in outpatient visits to specialists after 2012. The reforms were the most sweeping in the recent history of the service, and were led by then health secretary Andrew Lansley.

The study, reported in *PLOS Medicine*, looked at the effect of the Health and Social Care Act 2012, which introduced the clinical commissioning groups (CCGs) that gave greater control of secondary care budgets to GPs. Policy makers hoped that this would shift care away from hospitals to the community.

Specialist visits

Using routinely collected hospital episode statistics, the researchers tracked trends in all NHS outpatient specialist visits and hospital admissions in England between 2007 and 2015. They compared these figures with those in Scotland, where there was no similar reorganisation, as a control.

Their results showed no significant change in trends in hospital admissions in either England or Scotland. The change in slope for total admissions was −0.2% (95% confidence interval −0.6% to 0.2%) a quarter in both countries.

However, numbers of outpatient appointments in England increased nearly four times faster after the reforms were introduced in 2012 than before, with an increase in total outpatient visits to specialists per quarter of 1.1% (0.7% to 1.5%) (P<0.001). This resulted in a 12.7% higher rate of specialist visits each quarter by the end of 2015, giving a total of 3.7 million additional specialist visits than would have been expected from the trend before the reforms. There was no change in the rate of specialist visits in Scotland.

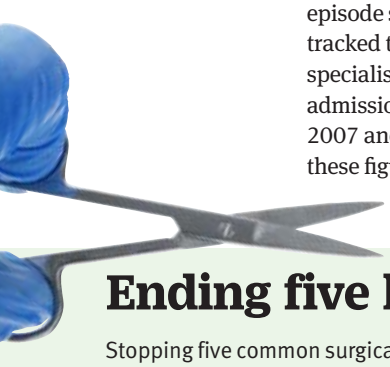
"Our findings suggest that giving control of healthcare budgets to GP-led CCGs was not associated with a reduction in overall hospitalisations and was associated with an increase in specialist visits," wrote the authors, led by James Lopez-Bernal, from the London School of Hygiene and Tropical Medicine.

Nigel Edwards, chief executive of the health think tank the Nuffield Trust, said, "This calls into question the entire basis of using commissioning as a model to effect this type of change. The scheme was based on a false premise and was very unlikely to work. It is not very surprising the reforms didn't have the effects expected."

Insufficient time

But Edwards cautioned that a major policy change of any type would take some time to show effects, so tracking hospital activity for only three years after the 2012 act might be insufficient. He added that Scotland may not have been a good comparator, as NHS Scotland introduced policy changes over the same period.

The researchers said, "The increase in specialist visits in our study was surprising and may be an unintended consequence of the [national] policy." They suggested, "One explanation might be that the new responsibility for managing budgets has inadvertently increased



Ending five low value procedures could save £135m a year

Stopping five common surgical procedures that are costly and provide limited benefit to patients, including inappropriate gastroscopy and inguinal hernia repair without major symptoms, could save the NHS £135m a year, a study has estimated.

"Identifying and stopping low value services represents a significantly greater opportunity for efficiency savings than previously thought," said the researchers, led by Humza Malik, clinical research fellow at Imperial College London.

"Clinicians should lead changes to provide pertinent, precise treatments, thereby avoiding ineffective interventions and challenging existing dogma that 'more care is better care.'"

Clinical effectiveness

Malik and his team analysed the clinical effectiveness and safety of procedures by reviewing published studies and by a targeted search of relevant databases. They then opportunistically sampled studies evaluating general surgical procedures or diagnostic tests against current practice, looking at their value and cost effectiveness.

Reporting in the *British Journal of Surgery*, they identified 71 general surgical services providing low value, which delivered little benefit to patients and could be replaced by less costly alternatives without affecting safety or quality of care.

The five services with the highest impact—most commonly performed and most costly—were: inguinal hernia repair in minimally symptomatic patients; inappropriate gastroscopy; interval cholecystectomy; computed tomography (CT) to diagnose appendicitis; and routine endoscopy in patients with CT confirmed diverticulitis. The estimated cost of these five was just over £135m a year.

Labelling pitfalls

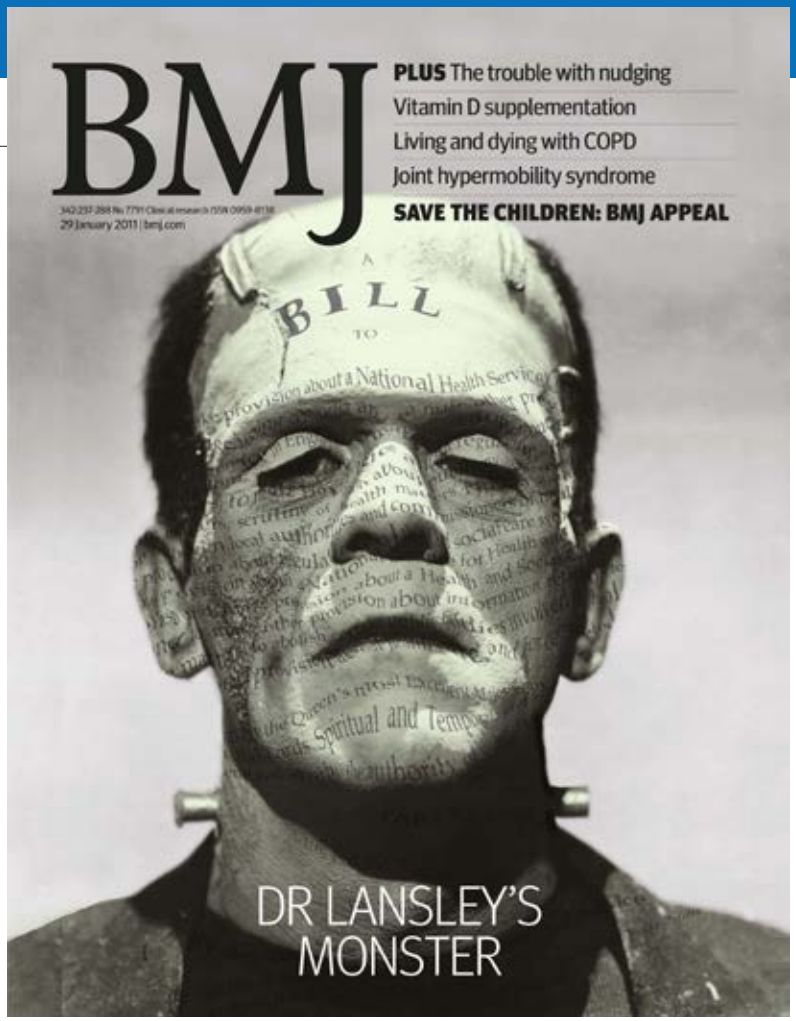
The authors warned of the pitfalls of labelling procedures as low value, because value depends on the clinical example. For example, trials showed that watching and waiting was equivalent to surgical repair of inguinal hernia in minimally symptomatic patients, but it was of high value in patients whose symptoms had worsened.

"It is important that stopping low value interventions happens only in correct clinical populations where the intervention is of little benefit," the authors concluded.

Susan Mayor, London

Cite this as: *BMJ* 2017;359:j5186

RESEARCHERS identified **71** general surgical services providing low value, which delivered little benefit to patients



administrative workload for GPs, resulting in less time to see patients. Under such circumstances, GPs may reduce their threshold for referral to avoid missing a diagnosis."

They suggested that other interventions might be needed to shift more care into the community.

Susan Mayor, London

Cite this as: *BMJ* 2017;359:j5253

"Weekend effect" deaths are not cut by clinical standards, study finds

Clinical standards designed to reduce mortality at the weekend have not made any overall difference, researchers have found.

In a paper published in the *Emergency Medicine Journal*, researchers from the University of Manchester said that four NHS priority standards for emergency care have not reduced excess deaths on Saturdays and Sundays.

The four priority standards measure the time to first consultant review, access to diagnostics, access to consultant directed interventions, and ongoing consultant review. By 2020, compliance will be mandatory for all hospitals in England, with financial penalties for those that do not meet them.

The researchers looked at data on the performance of 123 trusts against the standards in the summer of 2015 and compared them with figures on mortality within 30 days of admission in 2015-16.

They found that, while trusts that had met two of the standards (ongoing review and access to diagnostic services) had experienced a very small reduction in weekend mortality, overall the standards had made no difference to weekend deaths.

Compulsory compliance with the four standards, they concluded, may not be "the best way to allocate scarce NHS resources or increase overall quality of care provided."

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2017;359:j5185

ROUNDUP . . .

England LMC conference

Gareth Iacobucci reports from the GPs conference in London

GPs VOTE AGAINST PRIVATE WORKING

General practice leaders voted down a motion urging the BMA's General Practitioners Committee for England to help struggling GPs to operate privately and sell certain services outside the NHS. The motion at the conference on 10 November, proposed by Bedfordshire LMC, wanted to give GPC England a mandate to explore how to support GPs who "genuinely feel that they can no longer operate within the NHS" to operate "within a private, alternative model." But the vote was lost, after the GPC warned of how it might be reported in the media.

END "LOCAL RATIONING"

The Department of Health should undertake a review of prescribing regulations and entitlements and stop clinical commissioning groups putting pressure on GPs to reduce or limit their prescribing, LMCs voted. Some CCGs have been trying to limit prescribing of certain drugs, such as those sold over the counter, as part of cost saving drives, while NHS England has consulted nationally on similar plans. But Katie Bramall-Stainer (above), from Hertfordshire LMC, who proposed the motion, argued that any restrictions should be done via a formal blacklisting of specific drugs.

STRIP CAPITA OF SUPPORT SERVICES

Administrative and support services for GPs should be returned to public sector control and stripped from the private company Capita, GPs urged. Primary Care Support England has been beset by problems since Capita began providing the service in 2015. The conference said Capita had failed in its role and passed a motion urging that the service be publicly run to ensure proper accountability.

STEP UP INVESTMENT, GOVERNMENT TOLD

Politicians cannot afford to rest on their laurels, after recent steps to tackle the crisis in general practice, and must invest more in primary care and the wider NHS, said England's GP leader. In his keynote speech Richard Vautrey (below), chair of the BMA's General Practitioners Committee, called on politicians of all parties to support further investment to help build on steps already taken through NHS England's *General Practice Forward View* plan. "We need politicians and policy makers to start putting their money where their mouth is," he said.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2017;359:j5269

FIVE MINUTES WITH . . .

Charlie Auld

The surgeon says the rising number of perioperative practitioners need statutory regulation

"The faculty of perioperative care at the Royal College of Surgeons of Edinburgh was created in March 2016 to provide education, training, and support to perioperative practitioners in advanced roles. These practitioners have been working in the US for a while now and are becoming more common in the UK. This is a workforce that's only going to expand.

"There are different types of practitioner. Surgical care practitioners (SCPs) carry out preoperative and postoperative care and surgical intervention under the supervision of the consultant. Surgical first assistants assist in the operating theatre. There are also physician associates, acute critical care practitioners, and physician assistants in anaesthesia.

PRACTITIONERS NEED TO WORK TO THE SAME STANDARDS AS SURGICAL TRAINEES

"We need to ensure that practitioners such as SCPs are working to the same standards as surgical trainees. They should be assessed and appraised in the same way, they should keep a logbook of operative cases, and undertake the same workplace based assessments as trainees in relation to competence progression.

"Most of them have come from a nursing background and, although they're regulated by the Nursing and Midwifery Council or the Health and Care Professions Council, they're moving towards a more medical model of care so they should be regulated in a similar fashion. We support statutory regulation but are disappointed that the government has not recommended this in its consultation on the regulation of medical associate professions.

"The faculty of perioperative care at RCSEd has developed a membership process which reflects a certain standard to be achieved. There are trainee courses at universities for SCPs but once they have become fully fledged what further training or CPD do they have to complete? We're setting our own standards because there are no other standards out there."

Charlie Auld is lead of the faculty of perioperative care, Royal College of Surgeons of Edinburgh

Anne Gulland, London Cite this as: *BMJ* 2017;359:j5220

THE IMAGE BANK/GETTY IMAGES

NEWS ANALYSIS

Who really benefits from fast tracking breakthrough drugs?

Is the government's promise of faster access to transformative medicine and devices a good deal for patients? **Nigel Hawkes** reports

The government has promised NHS patients faster access to new drugs or technologies at no additional cost and without compromising safety.

The Accelerated Access Review follows almost 20 reports and reviews of innovation in the NHS over the past decade. Its aims have been generally welcomed despite doubts that any of them can be achieved, never mind all at once.

Barbara Harpham, chair of the Medical Technology Group, which works to improve access to technology, said she hoped that the measures would deliver. But she said that mandatory funding had not been promised for all guidance from NICE, adding that the aim of fast tracking just five new drugs or devices a year was not ambitious enough.

Roy Lilley, a blogger on NHS management, was unimpressed. Governments can't pick winners, he said, and its appointment of former GSK chief executive, Andrew Witty, to head the picking committee was a mistake because the NHS didn't trust pharma. The real story? "This has nothing to do with innovation or health or good ideas. This is signalling to the pharma boys… 'We love you, please stay.' This is about Brexit."

Lack of awareness

For most doctors, the review has remained below the radar. A survey commissioned by the BioIndustry Association in March found that only 11% of health professionals were even aware of it. The same survey found that, while 20% were aware of the Early Access to Medicines scheme that launched in 2014, just 5% recognised two earlier attempts, NHS Test Beds and the Innovation Scorecard. The NHS can talk the talk, but, wondered Steve Bates, the association's chief executive, can it walk the walk?

The government's proposition now is that a new committee, the Accelerated Access Collaborative (to be chaired by Witty), will identify five new "breakthrough technologies" each year to fast track through regulatory and market access, saving "up to four years." Why five technologies? Why four years?

The government provides no justification for the first figure, which lies at the low end of the range suggested in Hugh Taylor's 2016 report that originally outlined the plan. He estimated that five to 10 drugs or devices would qualify as "transformative" each year.

Taylor also provided a basis for the four year claim, arguing that 12 to 18 months could be saved in drug approval, two years in

Speeding up regulatory approval will mean that less is known about a drug when it reaches patients

gaining NICE cost effectiveness endorsement, and another two years in NHS commissioning and adoption.

Hilary Newiss, chair of National Voices, a coalition of charities, is also an adviser to the review. She said that medical charities are sceptical because, far from speeding up access, many recent NHS decisions are calculated to achieve the opposite—particularly the "budget impact test" agreed by NICE and NHS England, which allows the rollout of new medicines to be delayed for as long as three years if they would cost the NHS more than £20m a year.

The government announcement does not mention this but says that new technologies given the fast track must be "cost neutral." Any that are cost additive will need to be offset by products that deliver cost savings. So, companies eager to get expensive technologies on the market may have to cut the price of any existing products they have.

Efficacy and safety

Speeding up regulatory approval will mean that less is known about a drug when it reaches patients, which has implications for both efficacy and safety. As Taylor's report put it, "There is always a balance to be struck between accelerating access to medicines and ensuring that patients can be confident those medicines are safe."

A recent review of the US Food and Drug Administration's fast track schemes found that drugs so approved were subsequently associated with more safety related label changes than those approved by the regular route. This could possibly be the result of greater postmarketing surveillance, although the FDA does not mandate it.

On efficacy, the Early Access to Medicines scheme provides some reassurance. By this August, seven drugs originally provided under the scheme had been licensed and reviewed by NICE, and all gained approval as being cost effective.

But the scheme has benefited only a few hundred patients, and the claim at its launch that patients would get the drugs "12 to 18 months" before marketing authorisation proved false—the average being less than three months.

Nigel Hawkes, London

Cite this as: *BMJ* 2017;359:j5219

GMC push for erasure of paediatrician who was convicted of manslaughter

The GMC is to press ahead with a High Court appeal against what it considers a too lenient sanction on a paediatrician convicted of gross negligence manslaughter, despite a letter signed by more than 100 doctors urging it to reconsider.

Last June, a medical practitioners tribunal found that the failings of Hadiza Bawa-Garba were a causative factor in the death of 6 year old Jack Adcock from sepsis. But the tribunal decided not to accede to the GMC's call to strike her off the UK medical register.

Instead, it opted for a year's suspension, citing "multiple systemic failures," her unblemished record, and evidence from colleagues that she was an excellent doctor. The tribunal found that Bawa-Garba did not present a continuing risk and had already remediated her failings. In the circumstances, it said, erasure would be disproportionate.

More than 100 doctors have signed a letter to THE GMC

But the GMC decided to exercise its right to appeal against the ruling, which came into force in December 2015. More than 100 doctors, most of them paediatricians, have signed a letter to the GMC calling on it not to go ahead with the appeal, scheduled for 7 December.

The letter refers to evidence to the tribunal of "failings on the part of the nurses and consultants, medical and nursing staff shortages, IT system failures, the deficiencies in handover, accessibility of the data at the bedside and the absence of a mechanism for an automatic consultant review."

A GMC spokesperson said, "We never take the decision to appeal lightly and we only do so if, after careful consideration of all of the relevant circumstances, we conclude that a medical practitioners tribunal's decision was insufficient to protect the public."

Bawa-Garba, then a senior specialist registrar in paediatrics at Leicester Royal Infirmary, and a nurse were convicted of gross negligence manslaughter in November 2015 and received sentences of two years' imprisonment, suspended for two years.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2017;359:j5223

Legal challenge over data agreement that may put "migrants at risk"

A charity has launched a legal challenge to the data sharing agreement between the Home Office, Department of Health, and the NHS, which it says puts immigrants' health at risk by deterring them from seeking care.

The agreement, signed in January, enables the Home Office to access data such as a patient's home address. The Migrants' Rights Network says that the agreement was written in secret, without consultation with NHS staff, medical organisations, or the public. It says the agreement is "unethical and unlawful."

Fizza Qureshi, the network's director, said, "Health professionals should not be forced to act as immigration officers or to have to breach patient confidentiality. We want the NHS to live up to its founding principles, to be a place of help and support for those who need it regardless of their immigration status."

In its High Court submission, the network argues that the agreement violates a patient's right to privacy under the Human Rights Act.

Lara ten Caten, lawyer for the human rights organisation Liberty, described the agreement as "toxic." She said, "This case is an important step in the fight to dismantle this government's 'hostile environment' regime, which has seen the tentacles of immigration enforcement reach into schools and hospitals."

The network has launched a public appeal for funds on the crowdfunding site CrowdJustice.

The government said no clinical data were shared and it only requested personal data if all other attempts to find individuals had failed.

Anne Gulland, London

Cite this as: *BMJ* 2017;359:j5212

THE BIG PICTURE

Aid for quake survivors

A young girl, wounded in the earthquake that hit the Iran and Iraq border last Sunday, receives treatment at Sahra hospital in the province of Kermanshah, Iran.

At least 407 died and 6700 others were injured in the earthquake that measured 7.3 on the Richter scale.

Mansoureh Bagheri, director of international operations at the Iranian Red Crescent, told the US news channel CNN that more than 500 villages, many remote and hard to reach in the region, had suffered significant damage.

"The priority now is for emergency sheltering and food," Bagheri said. She estimated that 70 000 people could be affected.

Red Crescent volunteers in northern Iraq and Iran were among the first responders to the disaster and provided urgent search and rescue and first aid to victims.

Alison Shepherd, London

Cite this as: *BMJ* 2017;359:j5288

"The priority now is for emergency sheltering and food"
—Mansoureh Bagheri, Iranian Red Crescent

FATEMEH BAHRAMI/ANADOLU AGENCY/GETTY IMAGES

MAUDSLEY DEBATE

Has the Mental Health Act had its day?

Discrimination against people with mental ill health should be replaced with universal rules based on decision making ability, writes George Szmukler, but Scott Weich worries legal distractions won't improve outcomes while services are so stretched

yes

We have accepted such discrimination for so long because of deeply rooted, stigmatising stereotypes

George Szmukler, emeritus professor of psychiatry and society, King's College, London
george.szmukler@kcl.ac.uk

Patients with a "mental disorder" in England and Wales can be detained and treated against their will on legal grounds that are ethically unacceptable. These grounds contribute to the shadow of coercion that hangs over the practice of psychiatry. The law remains fundamentally unchanged since the late 18th century.

Two sets of rules exist for involuntary treatment—one for psychiatry and one for the rest of medicine. In comparing them, the discrimination against people with a mental illness becomes obvious.

In non-psychiatric cases, the person's ability (or capacity) to make a decision about treatment is key to whether over-riding a refusal can be justified. A refusal made with capacity is respected no matter what the health outcome might be. Even when capacity is lacking, an involuntary intervention is justified only if it is deemed to be in the person's "best interests." In assessing "best interests" the patient's personal values, beliefs, and commitments have a powerful role.

Capacity and best interests

These two considerations—capacity and best interests—have almost no role in initiating involuntary treatment in psychiatry. Two entirely different criteria operate: firstly, the presence of a "mental disorder," largely undefined; secondly, a perceived "risk" to the person's health or safety or of harm to others. Thus, autonomy (or the recognition of a right to self determination or to pursue personal goals and values) is not accorded the same respect as among patients with a non-psychiatric diagnosis.

In a pluralistic society such as ours, such attention to values is hugely important. The significant shift in medicine from "paternalism" to patient self determination over the past 50 years has passed psychiatry by.

Furthermore, the protection of other people in the "risk" criterion makes people with mental disorders uniquely liable to a form of preventive detention (albeit usually, or eventually, in hospital) on the basis of risk alone. They can be detained, unlike the rest of us, without first having committed an offence (or without being strongly suspected of having done so) and despite the fact that only a tiny proportion of violent offenders have a mental illness.

The blurred boundary of what constitutes a "mental disorder" may widen the net for involuntary detention to include people who are deemed to pose a threat to social order. Justice requires that all people posing an equal risk should be equally liable to preventive detention.

We have accepted such discrimination for so long because of deeply rooted, stigmatising stereotypes of people with mental illness—that is, that they are incapable of exercising judgment and that dangerousness is intrinsic to mental illness. Mental health law is shaped by both assumptions.

The blurred boundary of what constitutes a "mental disorder" may widen the net for involuntary detention to include some people who are deemed to pose a threat to social order.

Can we create a legal framework that is non-discriminatory? Indeed we can. Such a framework is based on decision making ability and best interests but also incorporates the regulation of detention and involuntary treatment with strong human rights protections. Robust assessments, with high agreement between assessors, can be made. A key point is that the law must be generic: namely, that it applies to everyone who has a problem with decision making, whether the diagnosis is physical or psychiatric, and in any setting—medical, surgical, psychiatric, or in the community. A specific "mental health" law is not necessary: the law should be formulated so as to apply throughout all medical specialties, from psychiatry to orthopaedics.

Fusion law can work

A "fusion law," covering mental health and mental capacity, is an example of such a generic law that Northern Ireland is due to implement in 2018. Fears that such a law will fail to protect the public are unfounded.

The moral case for reforming mental health law is decisive. The discrimination such law entails can no longer be supported. The solution for eliminating this discrimination is a generic law.

The authors are taking part in the 56th Maudsley Debate, next Wednesday, 22 November, at King's College London

no

Abandoning the MHA won't obviate the need for compulsory treatments. Lives would be lost, and more people in distress would go without help

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A world without compulsory mental health treatment is a commendable ambition. Psychiatrists are often accused of paternalism and coercion, and we know that compulsory treatment stigmatises patients, causes social rifts, and disrupts therapeutic alliances. Never having to "section" anyone would make our work easier. But it would substantially disadvantage those most in need of help.

It is unacceptable that more than 60 000 people were subject to the Mental Health Act in England last year and that black patients are three times more likely to be admitted compulsorily than their white counterparts.

The UN has said that the UK, and all signatories to the Convention of the Rights of Persons with Disabilities (CRPD), should repeal legislation authorising compulsory treatment in healthcare. The UK government has therefore commissioned another costly review of the MHA. Instead of tackling the parlous state of mental health services we're about to embark on further protracted legalistic debate.

What, then, of "fusion" legislation, which argues for compulsory treatment only when decision making capacity is impaired, irrespective of cause? Sadly, it's not CRPD compliant. Legal minds will be challenged to find a way around the fundamental CRPD principle that disability is a wholly social phenomenon, for which substituted decision making (in the best interests of people incapable of making decisions for themselves) is never permissible.

Capacity based legislation seems great from a moral perspective: like parity of esteem and personal autonomy, it's impossible to argue against equality under the law for people with physical and mental illnesses.

People in distress would go without help

So, why don't we abandon the MHA, as in Northern Ireland? Because it won't obviate the need for compulsory treatments—and won't placate the UN as things stand. But, more importantly, lives would be lost, and more people in distress would go without help. It would mean contravening other human rights, including the rights to health, liberty, justice, and life.

The MHA allows for compulsory treatment based on evidence of mental disorder plus risk. Restricting this to people judged to lack capacity would inevitably mean some going without treatment, even when it would be in their best interest. Judgments about mental capacity are notoriously complicated and variable.

Mental and physical illnesses differ. Mental disorders in general, and several specific conditions such as schizophrenia and mania, commonly lead to impairments in decision making capacity. Moreover, many patients approve of surrogate treatment retrospectively.

The law is not the problem. Only properly resourced mental health services can reduce rates of compulsion.

The act ensures that people get help

One of the paradoxes of the MHA is that its application obliges services to provide care. Only patients deemed most at risk can access psychiatric beds. In other words, they get help only because the MHA demands they get treatment. Consequently, psychiatric wards are more disturbed than ever. The number of patients detained after being admitted voluntarily has increased by more than 15% per year recently, and this year record numbers of staff have reported being assaulted.

Psychiatric bed numbers inversely mirror compulsory admission rates, and reductions predict compulsory admission rates in the next year. The determinants of compulsion in mental healthcare are more social than legal. From 2010 to 2015 NHS mental health budgets fell by an estimated 8.25%, local authority social care budgets fell 13.2%, and more than 2000 psychiatric beds were closed. And, although black patients are more likely to be assessed and admitted compulsorily than white patients, there is no evidence that ethnicity influences the outcome of MHA assessments.

We can't divorce the law from its setting. Focusing on the MHA is looking too far downstream and is a dangerous distraction. Unless services are properly resourced, changing the law won't make things better for patients, and it might make them much worse.

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

EDITORIAL

National commitment to shared decision making

The only way to achieve truly person centred care

NICE and NHS England are working with the Shared Decision Making Collaborative to encourage shared decision making in England.[1] The collaborative, established in 2015, brings together more than 40 individuals and organisations with a commitment to work to promote shared decision making in UK health systems, drawing on national and international expertise.

Its broad ambition is to make shared decision making the norm through clinical education, by making effective patient decision aids available, and by raising people's expectations of having an active role in determining the best care for them based on their values and preferences.

NICE is committed to developing decision aids based on clinical guidelines, and NHS England is committed to embedding shared decision making in its strategic and practical developments. NICE will also be developing a guideline to provide practical, evidence based recommendations for clinicians and patients, facilitating better conversations about healthcare options. These guiding principles for use across all healthcare will be strengthened by the production of specific decision aids to inform discussion about what individuals consider important.

Most clinicians support the idea of person centred care as a model of best practice, yet we know from published research and NHS patient surveys that people still want to be more involved in decisions about their healthcare.[2] In shared decision making, healthcare professionals support individuals to make informed decisions about investigations, referrals, and management. The information given should be based on the best available evidence of the likely benefits, risks, and outcomes of the various treatment options, with the individual's values and preferences being central to the decision.

People who are supported to make an informed decision seem to have better outcomes, better experiences, and less regret

Undervalued by doctors

Clinicians' attitudes suggest they often undervalue shared decision making.[3] Reported comments refer to lack of time or incentives and a belief that it is inappropriate for people with low health literacy, that it might prompt demand for inappropriate or expensive treatments, and that people would prefer to be given a definitive treatment plan.

People who are supported to make an informed decision by a healthcare professional seem to have better outcomes,[4] better experiences,[5] and less regret[6] about their decisions. Much is made of the need to reduce unwarranted variation in healthcare. However, shared decision making can provide context and legitimacy for variation when it results from incorporating people's values and preferences. Reliably informed, shared decisions lead to informed demand that, when applied across a pathway of care, can influence commissioning and service provision.

A Cochrane review found that people who use decision aids to support their choice of treatment are more likely to choose less invasive options than those who do not.[7] If these findings translate to real world populations shared decision making may have the secondary benefit of saving resources.

National programmes such as Choosing Wisely UK,[8] Prudent Healthcare in Wales,[9] and Realistic Medicine in Scotland[10] are designed to ensure value for public money and to prevent waste while further reducing the burden and harm people can experience from overinvestigation and overtreatment. When these programmes are effectively implemented they use shared decision making so that individuals can make informed choices about their care.

In 1998, Cyril Chantler, then chair of the General Medical Council's standards committee, famously said: "Medicine used to be simple, effective and relatively safe. It is now complex, effective and potentially dangerous. The mystical authority of the doctor used to be essential for practice. Now we need to be open and work in partnership with our colleagues in health care and with our patients."[11] Partnership has progressed slowly since then, and we hope this demonstration of national commitment by NICE, NHS England, and others will accelerate development of truly person centred care throughout the NHS.

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EDITORIAL

Simon Stevens speaks out over funding

An unprecedented public intervention that signals the boss of NHS England's deep concern

A minor earthquake shook the NHS last week. The epicentre of the earthquake was a speech by Simon Stevens, boss of NHS England, at the annual conference of trust leaders. Stevens used his speech to outline the consequences for patient care of continuing constraints on NHS funding ahead of the government's budget on Wednesday.

His starting point was that after seven years of unprecedented constraint, "the NHS can no longer do everything that is being asked of it." With funding increases in 2018-19 set to fall close to zero, he warned of services retrenching and retreating, waiting lists growing, and staffing levels falling. Planned improvements in priority areas such as cancer and mental health would not materialise, and the failure to provide extra funding would mean, in his view, turning back a decade of progress. Stevens made clear that the government has responsibility for deciding the NHS budget but added that politicians should be honest with the public about the consequences of their decisions.[1]

Brexit promise

These arguments are familiar, but the sight of the chief executive of NHS England articulating them on a public platform is not. Stevens suggested that one way of increasing funding would be for the government to honour the commitment made during the referendum on EU membership by the Leave campaign and provide the NHS with an additional £350m a week.

Although the government did not respond directly to the speech, a tweet by Nick Macpherson, a former permanent secretary at the Treasury, asserting it was "time for Mr Stevens to step down as an unelected public servant if he wants to campaign for more NHS funding"[2] perhaps reveals how Whitehall mandarins are likely to have felt.

Stevens's decision to go public is explained partly by the opportunity offered by the forthcoming budget to provide additional resources and partly by the apparent unwillingness of the chancellor and prime minister to engage seriously with the concerns he and others have raised. From the highest levels down, the government is preoccupied with Brexit, leaving limited time and attention for other public policy concerns. Uncertainty about the economic consequences of Brexit is also constraining the chancellor in the decisions he is weighing ahead of the budget.

Equally important is lack of sympathy in government for the claims being made for additional public spending. An indication of this was the speech by the home secretary, Amber Rudd, in which she scolded chief constables and police and crime commissioners for arguing for more resources to prevent and fight crime.[3] Jeremy Hunt seems more sympathetic to arguments for additional investment in the NHS but is reliant on the chancellor and prime minister to find the wherewithal.

Steven's speech might yet have consequences for his position, although as a public official accountable to an independent board he cannot be removed directly by politicians. His willingness to speak so frankly reveals the depth of his concerns about the prospects for the NHS and a sense that now may be the last opportunity to avert a crisis in care. If the government ignores these concerns, it cannot say it was not warned when others, including the Care Quality Commission, have argued that the NHS is overstretched and facing the likelihood of declining standards of care.[4]

Stevens's willingness to speak so frankly reflects a sense that now may be the last chance to avert a crisis

Simon Stevens' speech could have personal consequences

Fragility of government

The government's difficulties in recent weeks, and questions about its future, help explain why Stevens's intervention did not receive greater coverage in the media. His speech was made on the day that Priti Patel resigned as international development secretary, and speculation about her position dominated the news. The decision of news editors to lead with this story rather than concerns about the future of the NHS—concerns that have direct consequences for the entire population—reflects the febrile atmosphere in Westminster and the fragility of the government.

The noise around the travails of the government should not drown out the signal that Stevens sent in his speech. As the NHS approaches its 70th anniversary, the government and the public face some hard but unavoidable choices. Analysis by the King's Fund, the Nuffield Trust, and the Health Foundation has argued that an additional £4bn will be needed in 2018-19 to sustain services and provide a downpayment on the additional £20bn required between now and 2022-23. More resources also need to be found to shore up social care and to avert further damaging cuts to public health budget.[5]

Stevens has thrown down the gauntlet and challenged the government to respond.

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Winter crisis? What crisis?

As headlines suggest the NHS's imminent collapse, **Nigel Hawkes** asks health leaders what the reality is and if plans to prevent it have progressed

Winter provides a test of NHS resilience, each year foreshadowed by ever more claims that this time there really will be a major breakdown. No winter since 2012-13 has passed without warnings of crisis, each year's predictions more apocalyptic than the last.

Yet the NHS has managed to survive so far. The Care Quality Commission, England's health and social care regulator, last month reported that the quality of care is mostly good and improving overall. Public satisfaction has declined from its 2010 peak, when 70% of respondents declared themselves very or quite satisfied, but in 2016 it still stood at 63%—"high by historic[al] standards," says the King's Fund. Is the public blind? Is the NHS indeed on the verge of collapse, unseen by those it serves?

Last month, the annual warnings from health chiefs began in earnest. NHS Confederation chief executive, Niall Dickson, said there was "an even greater sense of foreboding this year than last," echoed by NHS England chairman, Malcolm Grant, who said: "We face winter better prepared than we have ever been but more scared than we have ever been." Andrew Foster, chief executive of Wrightington, Wigan and Leigh NHS Trust, tweeted: "A perfect storm of funding and workforce shortages vs an abundance of patients."

Although these warnings of a winter crisis are widespread, the doomsayers never specify how we would recognise one if it happened. The NHS is not going out of business like Monarch Airlines. Crisis is the wrong word since it implies an event that, once overcome, is history. The process is really more akin to slow strangulation, with winter tightening the ligature.

"The NHS does need to do winter planning. But it also needs to think how it's going to deliver services better in the future"
Tim Gardner, Health Foundation

"More will die"

The result is not the sudden disappearance of care but the slippage of targets and increasing safety risks, neither of which may be immediately apparent to patients. Taj Hassan, president of the Royal College of Emergency Medicine, says that last winter a large proportion of hospitals were dealing with less than 80% of patients within the four hour emergency department target.

"We know from many published studies that this creates a heightened risk of safety being compromised and patients being harmed," he says. "More will die, and more will come to harm."

Tim Gardner, senior policy fellow at the Health Foundation think tank, says the system of operational pressure escalation levels (OPELs), introduced last year to replace hospital black alerts, showed great variation across the English NHS, with some trusts under much greater pressure than others. "The pattern of OPEL levels three and four would flare up and then die away," he says. "The lights weren't all flashing red across the board all the time."

Alarm about winter pressures has prompted some extreme proposals, such as discharging patients into people's spare rooms to overcome the lack of social care places or preventing walk-in patients accessing emergency departments unless they have first consulted their general practitioner or NHS 111. Both ideas seem to have been killed at birth after attracting national publicity. The time is not yet ripe for solutions this radical.

Even if walk-ins were prevented, it probably wouldn't help. The winter problem (increasingly the year round problem) is not the numbers turning up at emergency departments but the ability of hospitals to manage the flow of patients through the system. In a report on last winter, NHS Improvement and NHS England (NHSI/NHSE) said that attendances actually fell by 1.7% compared with the previous winter, yet waits increased. "These delays are largely caused by poor patient flow through and out of the hospital," the report concluded.

GETTY IMAGES

Some of the report's 10 recommendations to be better prepared are exhortations—"a renewed drive and focus to implement best practice across all systems"—but a few are specific enough to put to the test.

Bed occupancy

For example, the first recommendation is that bed occupancy should be more actively monitored and actions taken to ensure it remains below 92%. For most of last winter occupancy levels exceeded this, peaking at 98% on 25 January 2017, despite trusts opening 4200 extra beds.

So achieving below 92% occupancy will be a massive challenge, even though NHS England's national urgent and emergency care director, Pauline Philip, says that plans are already in place to open at least 3000 extra beds. The latest figures, for the first quarter of 2017-18 (April, May, and June), show bed occupancy running at 89.1%, almost exactly the same as in the first quarter of 2016-17 (89.2%). This is 2.5 percentage points higher than the average for 2010-15, and there is no evidence of improvement.

The cause is not more patients arriving but fewer patients leaving. For years the NHS has enjoyed a favourable streak in which rises in admissions have been balanced by reductions in length of stay. Between 2001 and 2013 emergency admissions rose by 3% a year on average, yet emergency bed days rose by only 0.2% over the entire period, figures in a recent NHS England board paper show. Since 2013, the tide has turned and lengths of stay have increased by 1.8 million bed days, a 6% rise in four years.

The main reason is delayed transfers, which have risen steadily and increasingly swiftly since 2014. Reducing delayed transfers was a key recommendation in the NHSI/NHSE report, the aim being to free up 2000-3000 acute beds.

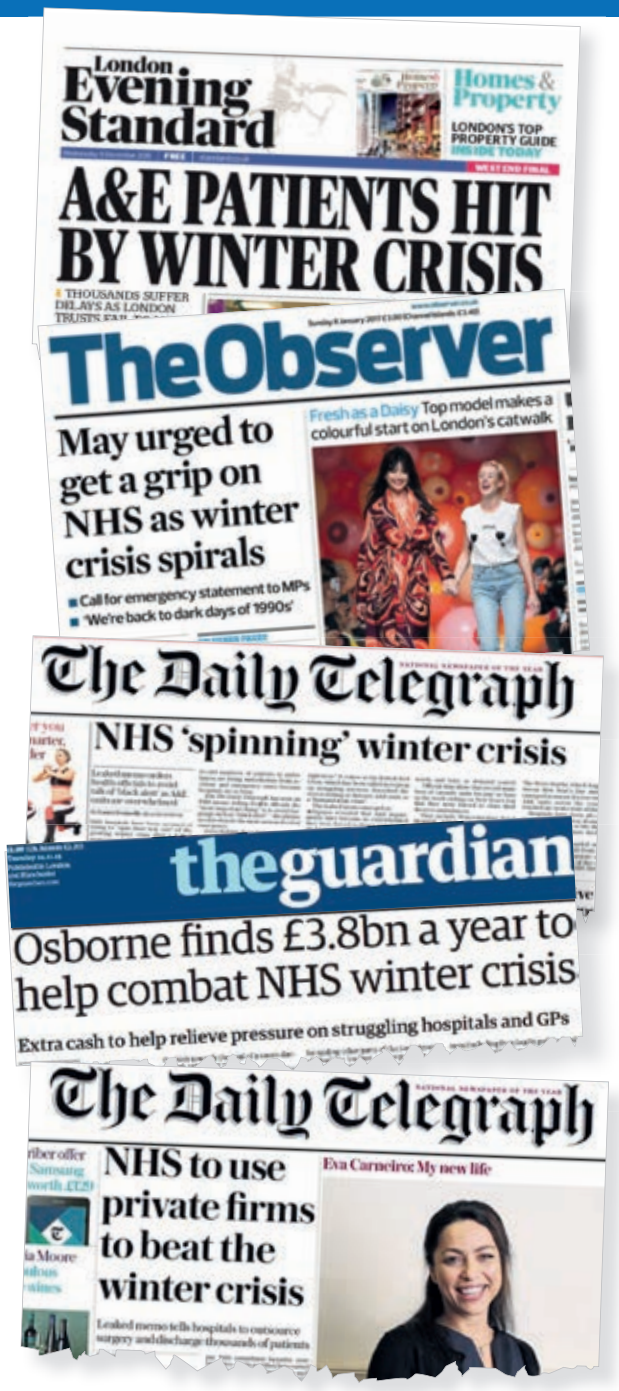
Is this much needed improvement happening? This August, the most recent month for which data are available, 5809 beds were occupied in English hospitals by patients whose discharges had been delayed. Although this is marginally lower than the 6060 reported in the same month in 2016, the difference is insignificant. NHS England admits that "to date, only limited progress has been made" in reducing delayed transfers. Chris Hopson, chief executive of NHS Providers, the organisation for trusts, says more bluntly that the plan has failed.

Gardner sums it up: "The aim was to get the proportion of occupied bed days down from 5.6% to 3.5%, roughly where it was three years ago. That amounts to making up three years' change in a few months, and it's going to fall some way short."

Local authorities blamed

The finger is being pointed at local authorities. Delays attributable to social care are fewer than those where the blame lies with the NHS but are rising more swiftly, both in numbers and as a proportion; 37.3% of the delayed transfers in August 2017 are laid at the door of social care, compared with 33.5% the year before.

The government promised local councils an extra £2bn to ease the strain but told them in July that the money was linked to performance targets, amounting in some cases to a 70% cut in delayed transfers, which the



Newspaper headlines have fed into fears of a winter crisis

County Councils Network described as undeliverable. In a letter from the health secretary, Jeremy Hunt, and communities secretary, Sajid Javid, 32 councils with high rates of delayed discharges were told that if progress wasn't evident by September they stood to lose their share of the new money.

Workforce shortages

Another specific recommendation in the NHSI/NHSE report was the need to remedy workforce shortages in primary care and in urgent and emergency medicine. NHS staffing statistics do show some rises in staff

PA

Backed up: ambulances wait in January 2017, during the NHS's last "worst winter ever"

classified as working in emergency medicine. In June this year (the latest figures available) there were 1648 consultants and 1751 specialist registrars so recorded, against 1486 and 1594 in June 2016.

NHS England announced a year ago that there would be extra money to boost GP numbers, but the statistics do not show any clear sign of this proving effective. Comparisons between years are difficult because changes have been made to the way the data are collected, but the message is that although the GP headcount may be rising slowly, the numbers of full time equivalent GPs are not.

More mortuaries

Another key to navigating winter, say NHSE and NHSI, is getting the planning done early. A common feature of published plans, as in every winter, is postponing elective operations to free beds for emergency admissions.

At the Maidstone and Tunbridge Wells Trust, for example, almost all elective work will be halted at the Tunbridge Wells site and, in a move unlikely to provide much reassurance, mortuary capacity will be increased by 100, possibly by installing a mobile mortuary on site. At Portsmouth Hospitals, where meeting the four hour emergency department target is a distant dream (in August it was met for only 74% of patients), the chief executive, Mark Cubbon, plans a six month reduction in elective work to try to get things right, even though this will reduce the trust's income.

Similar expedients have got the NHS through recent winters, though some say that luck has played a part. In 2014-15, mortality soared but nobody much noticed at the time and similar trends were seen across Europe so blaming NHS winter pressures seems unjustified. The most likely cause was a poor match between the circulating flu virus and the vaccine.

Estimating how much damage flu could do this winter is largely guesswork. Despite some headlines, Australia's flu season, just coming to an end, has not been especially bad. Laboratory confirmed cases are up sharply, but new rapid testing introduced this year makes comparisons with previous years difficult. Clinical severity has been low to moderate, the Australian Department of Health says, and the vaccine seems to be a good match with the circulating virus.

Given that the NHS has so far survived the annual prophecies of doom, are this year's any more believable? Gardner does see dangers in focusing too much on the short term. "The NHS does need to do winter planning," he says. "But it also needs to think how it's going to deliver services better in the future, and there are lots of good examples. But these changes take a very long time—you can't just cut and paste them from one area to another.

"In worrying about meeting winter pressures, the NHS shouldn't forget longer term changes. It has to do both."

Nigel Hawkes, freelance journalist, London

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PERSONAL VIEW
Taj Hassan

"Each winter is an exacerbation of a downward spiral"

Taj Hassan is an emergency medicine consultant at Leeds Teaching Hospitals, and president of the Royal College of Emergency Medicine

"Over the past five years the NHS has been on a steady downward spiral. During each autumn and winter we get an exacerbation of this spiral.

"There's a combination of things that makes our departments very crowded: increasing demand, increasing complexity, and the steady decrease in acute beds. What's made it worse over the past two or three years is that the amount of money for social care is also declining.

"Last year was the worst in 15 years. If you look at us now, the four hour standard as we enter the winter is as bad if not worse than it was last year. So this year potentially could be worse—even [NHS England chief executive] Simon Stevens is saying that we could be 3000 beds short of what we need.

"We're very lucky that NHS staff always step up to the plate, but we're facing certainly one of the toughest winters for the past 15 years. We absolutely need to unblock delayed transfers of care, so we need more social care packages in the community, we need more acute beds.

"The workforce issue in emergency departments is acute—the NHS is spending £1.3m a day on locums. A new workforce strategy we've just agreed with NHS England, NHS Improvement, and Health Education England aims to establish more permanent substantive posts. The fact that we have got the three most senior execs of the NHS to sign up for this is a real positive."

"NHS staff always step up to the plate, but we're facing one of the toughest winters for the past 15 years"
Taj Hassan