Overhaul of child mental healthcare

Children and young adults in England should be able to access NHS funded mental health services within four weeks as part of a government pilot scheme.

The measures in the green paper, Transforming Children and Young People’s Mental Health Provision, will be funded by £300m government spending. Consultation on the paper, which builds on the 2015 Future in Mind report, will run until 2 March.

The government proposes incentives for every school and college to have a named mental health lead by 2025. They will help staff spot pupils who show signs of mental health problems, and refer children to specialist services if needed. Currently, around half of schools and colleges have a dedicated mental health lead, 61% offer counselling, and 90% offer staff training to support pupils’ mental health needs.

The chief medical officer is also to produce a report in 2018 examining the impact that technology has on children and young people’s mental health.

The green paper says that the significant variation in access to child and adolescent mental health services is not good enough. Waiting times for treatment can vary considerably, with the shortest wait around four weeks and the longest up to 100 weeks from referral to treatment. The latest data show that in 2016-17 the average wait was 12 weeks. The new approach will start with a number of “trailblazer” areas, operational from 2019. This will be expanded to at least a fifth of the country by the end of 2022-23. The pilots will explore different models depending on local need.

Bernadka Dubicka, chair of the child and adolescent faculty at the Royal College of Psychiatrists, said: “One of the biggest problems is children who do not meet thresholds for mental health treatment falling through the gaps. It is promising to see the government looking to tackle this.”

She added: “Proposals for much needed research, and for piloting four week waiting time targets, are welcome. But it is crucial there is enough resource available for the quality of care to remain consistently high.”

Barbara Keeley, the shadow mental health minister, said: “This leaves many unanswered questions, in particular whether the reported funding will amount to new investment and whether the incentives offered will lead to every school being able to offer proper mental health support to pupils.”

Jacqui Wise, London

Cite this as: BMJ 2017;359:j5652

Schools will be given a greater role to help their pupils access NHS mental health services

LATEST ONLINE
- GP who falsified prescriptions to treat his depression is suspended for 12 months
- US tax bill destroys central pillar of Obamacare
- Heart surgery units will stay open provided they meet standards
New test for asthma will “save NHS millions”

GPs should diagnose asthma using objective tests including fractional exhaled nitric oxide (FeNO) and spirometry, NICE recommends (www.nice.org.uk/guidance/ng80). However, it says the change will take time to implement, with extra primary care infrastructure and training needed.

NICE said relying on signs and symptoms of asthma without objective testing can lead to overdiagnosis. It estimates that objective tests could save between £10m and £15m over five years, mainly through reducing unnecessary prescriptions.

To implement the guideline, NICE suggests that clinical commissioning groups should consider establishing asthma diagnostic hubs to make testing more efficient and affordable, as the FeNO equipment can cost up to £2540, plus maintenance fees.

Andrew Menzies-Gow, consultant in respiratory medicine at the Royal Brompton and Harefield NHS Foundation Trust and co-chair of the guideline committee, said: “Our recommendations will help tackle inappropriate diagnosis and ensure that if a diagnosis is given, the person is monitored to ensure their symptoms still indicate asthma.”

Jacqui Wise, London  Cite this as: BMJ 2017;359:j5540

Immigration

Scrap detention centres to protect migrant health

Immigration detention centres should be phased out and replaced with more humane means of monitoring people who face removal from the UK, a BMA report says. It warns that staff shortages and problems in assessing patients lead to detainees failing to get the same healthcare as the general public, adding that people with complex needs may not be properly treated in detention. The report also recommends a clear limit on how long people can be held in detention, saying that healthcare rights should not be infringed.

Research

Consultation to simplify trials in NHS is launched

NHS England is consulting on how to simplify the processes involved in conducting research studies (http://bit.ly/2iYo3d2). It says that common problems include excess treatment costs and delays in confirming multisite trials. Bob Bell, chair of the Association of UK University Hospitals, said, “A great strength of the NHS is its ability to conduct clinical trials at scale. But with this scale can come inefficiency, which is costly in time and money. With government and NHS now looking at how to make the UK as attractive a place as possible in which to conduct research, it’s the ideal time to target and reduce these barriers.” The consultation closes on 1 February.

Falls

Trust is fined £333 000 over five deaths from falls

Shrewsbury and Telford Hospital NHS Trust was fined £333 000 and ordered to pay £130 000 in costs after it was prosecuted by the Health and Safety Executive for failing to protect five elderly patients who died after falls in hospital. Mr Justice Haddon-Cave (below) said the trust had had inadequate risk assessment, handover, and enhanced care arrangements in 2011-12, when the falls occurred. He ruled that the failings were a significant cause or contributory factor in four of the five deaths.

Negligence

 Ministers must act on spiralling claims

MPs on the Public Accounts Committee said that a mixture of increasing efficiency targets, rising financial pressures, and longer waiting lists raised the risk of clinical negligence claims “spiralling out of control.” They said that the Department of Health, the Ministry of Justice, and NHS Resolution should review the adequacy of current legislation—which requires damages awards to assume that patients will require private care, even if they will receive free NHS care—and should report back to the committee by April 2018.

Diabetes

Adults as likely as children to develop type 1 diabetes

Over 40% of new type 1 diabetes cases occur after age 30, researchers from Exeter University found, overturning previous assumptions that the disease develops in childhood. The researchers used a novel genetic analysis to identify type 1 diabetes in 13 250 adults in the Biobank database who developed the condition in their first six decades of life. Richard Oram, consultant physician and one of the researchers, said, “The assumption among many doctors is that adults presenting with the symptoms of diabetes will have type 2, but this misconception can lead to misdiagnosis with potentially serious consequences.” Failure of tablets to control blood glucose and being slim are clues to a type 1 diabetes diagnosis, he wrote in Lancet Diabetes and Endocrinology.

GP based weight loss plan can reverse type 2 diabetes

Almost a quarter (24%; 36/149) of people with type 2 diabetes who followed a low calorie diet (825-853 calories/day) for three to five months, followed by a 28-week stepped food reintroduction and support for weight loss maintenance, achieved weight loss of 15 kg or more at 12 months, and nearly half (46%) achieved remission at 12 months. No one in the control group lost that amount of weight, and only six people went into remission, a study in the Lancet found. The researchers called for widespread use of weight management plans as a routine part of care.

Cite this as: BMJ 2017;359:j5540

9 December 2017 | the bmj

Jacqui Wise, London
MEDICINE

Research news
New drugs halve migraine frequency
A new monoclonal antibody that inhibits the calcitonin gene related peptide (CGRP) receptor, which plays a central role in migraine, halved the frequency of migraine episodes in a phase III randomised trial to investigate erenumab. A second trial with another new agent blocking the same peptide, fremanezumab, halved the frequency of headache in patients with chronic migraine. The researchers said that further trials were needed to determine the drug’s long term safety and the durability of its effects.

Varicoceles may link to heart disease and diabetes
Men with symptomatic varicoceles showed a higher risk of heart disease, diabetes, hyperlipidaemia, or other comorbid disease, a study in Andrology found. The findings show that varicoceles may be an early marker of metabolic disorders. Nancy Wang, study author and a urologist at Stanford Hospital in California, said, “Varicoceles are associated with low testosterone, which in turn is associated with metabolic risks and heart disease. No one has connected the dots before now.”

Radiology
CQC reviews reporting throughout NHS
The Care Quality Commission asked all radiology departments in England to report details of their backlogs, turnaround times, staffing, and routine reporting after it found that untrained junior staff was connected to downs. The Care Quality Commission (CQC) reviews reporting throughout NHS through its reviews with NHS trusts. The act has been in place for two months before the change it has had 104 donors, compared with 101 in the 21 months before the act.

ORGAN DONORS
Wales has seen no increase in organ donors since it adopted an “opt-out” system for donation on 1 December 2015. In the 21 months since the change it has had 104 donors, compared with 101 in the 21 months before the act

State to allow voluntary euthanasia from 2019
Victoria became the first state in Australia to legalise voluntary euthanasia. From mid-2019, adults who face intolerable suffering and have fewer than six months to live will be able to apply for an assisted death.

New drug that blocks migraine linked peptide halved headache episodes
Hospital in Portsmouth were reviewing images. Inspectors discovered a backlog of 23,000 chest x rays and found three serious incidents where patients with lung cancer had experienced significant harm because they were not properly assessed.

Australia
Ban on mesh for prolapse and urinary incontinence
Australia banned the use of transvaginal mesh for treating pelvic prolapse and urinary incontinence after reviewing the latest studies and clinical outcomes of its products. The Therapeutic Goods Administration said that the benefits of mesh do not outweigh the risks for these conditions. The move comes a week after NICE announced plans to ban mesh to treat prolapse, in draft procedural guidance due to be published on 20 December.

State to allow voluntary euthanasia from 2019
Victoria became the first state in Australia to legalise voluntary euthanasia. From mid-2019, adults who face intolerable suffering and have fewer than six months to live will be able to apply for an assisted death.

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SIXTY SECONDS ON... FLU VACCINE FOR HEALTH STAFF

Routine, isn’t it?
Not at all. Scarcely half of those in the NHS get an annual flu vaccination, despite repeated urging.

Why not?
They don’t think they’re at risk; they’re afraid it will make them unwell; they think flu is a minor illness and, frankly, getting vaccinated is a bit too much trouble. Those are the commonest excuses.

Not exactly compelling
No, especially in light of a new study showing that increasing vaccination rates reduces days off. For every 10% increase in the vaccination rate, sickness absence fell by 10%, a team from the London Respiratory Network has found, using data from 223 trusts and 800,000 staff over four flu seasons from 2011. This period coincided with an increase in vaccination from 44% in the first two winters to 54% in the past two, and that increase coincided with a fall in the sickness absence rate of 0.43 percentage points.

Could be a coincidence?
That’s possible, because a study like this can’t prove cause and effect. And higher vaccination rates could be just a marker for trusts that are good places to work and whose staff throw fewer sickies. But incorporating staff satisfaction scores into the analysis didn’t upset the findings.

Doesn’t flu vary year to year anyway?
That was also accounted for, together with vaccine effectiveness, which also varies. The drop in absences was only seen in the winter, not in the summer, strengthening the link to vaccination.

A careful study then, but will it make any difference?
Study author Nick Hopkinson, from the Royal Brompton Hospital in London, thinks it should. Though having a vaccination that reduces your chances of taking a few days off in the darkest months of the year when work pressures are intense might not appeal to everybody.

Nigel Hawkes, London
Cite this as: BMJ 2017;359:j5629
NHS advises GPs not to prescribe “low value” drugs to save money

NHS England will issue guidance to GPs and commissioners to limit the prescribing of “low value” treatments, as part of a drive to cut costs and unwarranted variation.

The NHS will also further consult with patients on restricting over-the-counter drugs, such as paracetamol for minor, short term conditions, which it estimates will save £190m a year.

The proposals were approved by NHS England’s board on 30 November, after an initial public consultation. GPs and clinical commissioning groups will now be advised to restrict the prescribing of 18 “ineffective, unsafe, and low clinical value” treatments (see box, right), which NHS England says will save up to £1.14bn a year.

In a board paper outlining the plans, NHS England said CCGs would be expected to take its guidance into account in their policies, while clinicians “should reflect these local policies in their prescribing practice.”

Not a blacklist
But it emphasised the guidance would not amount to a blacklist or formal ban. “This guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties,” NHS England said.

The patient consultation on cutting the number of prescriptions for drugs that can be bought over the counter will also assess whether to recommend stopping products being prescribed for self-limiting conditions.

NHS England chief executive, Simon Stevens, said, “The NHS is one of the most efficient health services in the world, but we’re determined to make taxpayers’ money go further. The NHS should not be paying for low value treatments, and it’s right that we look at reducing prescriptions for medicines patients can buy for a fraction of the price the NHS pays.”

Graham Jackson, co-chair of NHS Clinical Commissioners and clinical chair of NHS Aylesbury Vale CCG, said, “The guidance, which resulted from work we initiated on behalf of our members, will support clinical commissioners to prioritise effectively and make sure they are getting the best value for their medicines spend.

“We need to carry on having these honest, open conversations on what the NHS can and should provide with the funding it has, and consider what local patients need.”

Scottish delegates back new GP contract

The proposed new contract for family doctors in Scotland has been backed by local medical committees where the Scottish government announced plans to recruit an extra 800 GPs over the next 10 years.

LMC leaders were asked for their views on the potential of the contract to cut workloads, make the service more attractive, and reduce the risks of owning premises and employing staff. In each case there was a majority in agreement, with votes of between 79% and 85% in favour.

The deal, agreed between the BMA and the Scottish government, seeks to establish GPs as “expert medical generalists” leading expanded community teams. It allows for responsibility for some services (such as vaccinations) to be passed to health boards without losing funding. Practices in deprived areas and with high proportions of elderly patients will benefit, and a guaranteed minimum income of just over £80,000 is offered for GPs partners.

Interest free loans will help with premises as part of a long term move towards relieving GPs of the need to own their own practices. The conference’s positive reaction contrasts with opposition elsewhere. An online poll in Highland LMC found 72% of respondents were opposed, with only 11% in favour. And the Rural GP Association of Scotland has warned that the funding formula being used in the contract would see a massive shift of cash from rural to urban areas.

Salaries by stealth
Delegates were also concerned the contract marked a “salaried service by stealth,” a possible loss of autonomy, and undervaluation of rural general practice, but Alan McDevitt, the BMA’s Scottish GP committee chair, rejected the criticisms. “This provides a brighter and more sustainable future.”

A poll in Highland LMC found that 72% of respondents were opposed to the new contract, with only 11% in favour.

Cite this as: BMJ 2017;359:j5634

I TRULY BELIEVE THIS WILL DELIVER A BRIGHTER AND MORE SUSTAINABLE FUTURE

ALAN McDEVITT, BMA

“Deprived patients living in more affluent areas might have particularly high levels of unmet health need.”

Helen Stokes-Lampard, of the Royal College of General Practitioners, said, “One of our objections to charging patients when they miss appointments has always been that this could disproportionately impact on the most vulnerable, and this new research backs this up.”

Jacqui Wise, London

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much needed additional resources. It will give us more time with our patients and will make sure they have access to a wide range of professionals more quickly and more locally.

“I truly believe it will deliver a brighter and more sustainable future.”

Scotland’s health secretary, Shona Robison, told delegates of plans to recruit an extra 800 GPs and to spend £7.5m in 2018-19 on incentives for all 160 rural practices in Scotland. “Golden hellos” of £10 000 will be on offer, plus £5000 relocation packages.

GPs in Scotland can vote on the contract until 4 January. The final decision will be taken by the BMA’s Scottish GP committee on 18 January.

“The rationing of treatments should not be targeted at those most in need”

Don Redding, National Voices

The following treatments are considered by NHS England to be relatively ineffective, unnecessary, inappropriate, or unsafe for routine prescription in primary care.

Treatments that should no longer be routinely prescribed
- Homeopathy
- Herbal treatments
- Omega 3 fatty acid compounds
- Co-proxamol
- Rabeprazole (excluding topical non-steroidal anti-inflammatory drugs)
- Lutein and antioxidants
- Glucosamine and chondroitin

Treatments recommended for restricted prescribing
- Dosulepin
- Prolonged release doxazosin
- Immediate release fentanyl
- Lidocaine plasters
- Lithium
- Oxycodone and naloxone combinations
- Paracetamol and tramadol combinations
- Perindopril arginine
- Once daily tadalafil
- Travel vaccines
- Trimipramine

Source: NHS England

“Hunt must create 1500 foundation places”

The government must ensure there are enough foundation training places to accommodate 1500 new students, the BMA has said.

In 2016 the health secretary, Jeremy Hunt, announced that an extra 1500 doctors would be trained in England from September 2018. So far, 500 new places have been allocated to existing medical schools. Universities were able to bid for the remaining 1000 places in a process which closed on 23 November. However, there has been no commitment to increase the number of foundation training places available to medical graduates in line with the increase in medical school places.

Sarah Hallett, deputy chair of the BMA Junior Doctors Committee, said that despite current undersubscription in the foundation programme, places are needed to accommodate the increase in graduates. “This year the UK Foundation Programme Office said that, while there will be around 143 applicants placed on the reserve list in March 2018, there will be around 242 vacancies at the start of the programme as there is usually a withdrawal rate of around 7%,” she told The BMJ.

“However, there needs to be over 1000 new places for when these students come out of medical school.” She added, “On the surface, the announcement of 1500 new medical students per year should be a cause for celebration, but there has not yet been any associated commitment for funding or any more foundation places.”

Hallett said the government needed to ensure that the funding would also be in place. “We know trainers are already struggling with their workloads, and these new trainees will need mentorship, training, and facilities,” she said.

Workforce plan

Last month, Hunt announced that the NHS would have a draft workforce plan by the end of this year for the first time since 2000. Hallett said she hoped the plan would explain how this extra training would be provided.

“We very much hope that the government is going to outline how it is planning on tackling this problem,” she said. “If it’s not contained in the workforce plan, then we are going to be asking for further announcements.”

The BMJ approached the Department of Health for a comment but did not receive a response in time for publication.

Sarah Hallett, deputy chair of the BMA Junior Doctors Committee, said that despite current undersubscription in the foundation programme, places are needed to accommodate the increase in graduates. “This year

The BMJ

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Gareth Iacobucci, The BMJ

Cite this as: BMJ 2017;359:j5626

MARGARET McCARTNEY, p 399

Bryan Christie, Glasgow

Cite this as: BMJ 2017;359:j5633
Visa problems are depriving the NHS of GPs trained in the UK, doctors warn

The NHS is losing GPs from overseas who have trained in the UK, because of difficulties in applying for visas, doctors have warned.

The House of Commons Health Committee put out a call last month for examples of GPs from outside the European Economic Area who had been unable to work or had been forced to leave because of visa problems.

In August NHS England announced that it would aim to employ 600 GPs from overseas in 2017-18 and “at least” 2000 doctors from overseas by 2020-21. The NHS will spend £100m on agency fees over the next three years to recruit these doctors.

Despite these ambitions, figures shared with The BMJ in July showed that only 38 GPs had been recruited through the International GP Recruitment Programme.

John Coffey, a GP and training programme director from Lincolnshire, said it was frustrating that the NHS was actively recruiting GPs overseas when GPs who trained in the UK were struggling to remain and work. He said that in his part of Lincolnshire doctors from outside the EU who had completed their UK GP training were struggling to get a tier 2 visa, issued to workers outside the EEA and Switzerland who have been offered a skilled job in the UK by a licensed sponsor.

“These doctors are trained in the area, they are settled, and they want to stay. Suddenly there are barriers in their way and they can’t work, and we are losing them,” said Coffey.

Part of the problem, he said, was that it was difficult for general practices to get the certificate that allows them to act as a sponsor. “Our practice failed three times because we didn’t know what to fill in. And doctors aren’t straightforward: they’re not nine to five like other workers,” he said.

“In hospitals it’s always quite easy to get a job, and easy to get a visa sorted, to get a GP job it’s quite difficult”

Coffey also said that the six to eight weeks it took for applications to be processed prevented GPs from securing a job in time to meet the visa deadline. He said that local practices were struggling to recruit and needed overseas doctors to fill the gaps.

“Across Lincolnshire we reckon we’ve had about 14 doctors who have finished their GP training and needed a visa extension. If 14 doctors can’t work, then that’s a big loss.”

Mervin Wong is a GP who has been through the process of applying for a tier 2 visa. Originally from Brunei, Wong completed his medical degree in Scotland and undertook GP training in Lincolnshire. He said that during his training the visa process had been “seamless,” as it was covered by Health Education England. “I finished the training scheme in August 2016, and then the hard part came,” he said. “What happens after you achieve your certificate of completion of training is HEE doesn’t cover your visas any more. So I needed to find a job,” he said.

“In hospitals it’s always quite easy to get a job, and easy to get a visa sorted, to get a GP job it’s actually quite difficult.”

In Lincolnshire at the time, Wong said, only one general practice could sponsor visas, but it was in difficulty and wasn’t sponsoring any more doctors. “What I had to do then was to try to find a surgery that would be willing to hire me, be willing to listen to what I needed, from a visa perspective, and then actually go on to become a visa sponsor,” he said.

Perseverance with paperwork

Wong eventually got his visa, partly due to the perseverance of his employer’s practice manager. “I have heard anecdotally of friends who have had issues with visas and GP practices who, unfortunately, after facing barriers with paperwork don’t follow on with it. It’s easier for them to try to get a local graduate than to go through the process to become a tier 2 sponsor.”

Another GP, from Nigeria, who wished to remain anonymous, was not so lucky. She was asked to leave shortly after finishing GP training in Lincolnshire. Complications with finding an employer who could sponsor her visa meant that she did not apply in time.

She had to wait 12 months before reapplying. However, the process is even more complicated when the applicant is no longer in the UK. “It’s not just about looking for a job, it’s about looking for a practice that has sponsorship status or that is willing to apply for sponsorship status,” she said.

Other doctors in the same position have ended up taking any job in the UK, rather than risk losing their visa, she said. “I know someone who ended up working in an urgent care centre in Cumbria, which was something he didn’t want. They box you into a situation where it’s either that or leave.”

Abi Rimmer, The BMJ  Cite this as: BMJ 2017;359:j5642
NEWS ANALYSIS

NHS and government are on a funding collision course

While health managers and politicians clash over money, it’s patients who will suffer as waiting lists grow, reports Gareth Iacobucci

Last week NHS England took the unprecedented step of warning that it may be forced to abandon waiting time targets and the implementation of new clinical guidelines next year because of a lack of funding from central government.

The stark missive was issued at a board meeting, in response to what most NHS leaders viewed as an inadequate settlement for the health service in the chancellor’s budget on 22 November.

While Philip Hammond gave the NHS an extra £1.6bn for 2018-19, this fell short of the £4bn that policy experts and NHS England’s chief executive, Simon Stevens, said was needed to maintain services at current levels next year.

In light of the settlement, NHS England has called for realism about what can be delivered from the available funds. It warned that standards on waiting times “will not be fully funded and met next year” and that NICE guidelines may not be implemented because of a lack of funding.

Sacrifices in these areas, Stevens argued, would allow planned investment in mental health, cancer care, and primary care to be protected, along with important standards for treatment in emergency care.

“Low value” treatments

NHS England is pressing ahead with plans to issue guidance to GPs and commissioners to limit the prescribing of “low value” treatments on the NHS and will consult further with patients on plans to restrict prescribing of drugs available over the counter, such as paracetamol, as part of its ongoing cost cutting drive (see p 382). Financially, these are desperate times.

But will this pre-emptive strike cut any ice with a government that wants to hold the NHS, and Stevens in particular, to account for maintaining standards?

The health secretary, Jeremy Hunt, responded swiftly to the warning, emphasising that the government expected waiting time standards to be met, given the “significant increase” the NHS received in the budget.

Policy experts say that the negotiations over next year’s NHS mandate, which must be agreed with the Department of Health before April, will be a tense affair as the two sides thrash out where the priorities should lie next year.

Sacrifices on waiting times and guidelines would allow investment in mental health and cancer and primary care

Sally Gainsbury, senior policy analyst at the Nuffield Trust think tank, told The BMJ that a potential standoff over waiting times was likely. “On the day of the budget, the Treasury and the department seemed to suggest that the extra £1.6bn would be very tightly tied to the achievement of referral to treatment waiting times and A&E,” she said. “But at the board meeting it sounded like NHS England believed that was still to play for. NHS England were very clearly setting out their stall that cancer, primary care, mental health were not areas which could be cut. That effectively just leaves elective care, which is why we’re potentially in a standoff situation.”

Common ground

Chris Ham (above), King’s Fund chief executive, said he believed that NHS England and the health department actually had “a lot of common ground” on some issues. The biggest challenge, he argues, is for the NHS to convince the Treasury and No 10 of the need to invest more in the NHS.

“I think it would be wrong to characterise this as a big falling out between Hunt and Stevens,” Ham told The BMJ. “My reading is that Hunt, both publicly and privately, has been clear about the argument for additional funding.

“The bigger issue is how far these issues are really understood at the heart of government. Quite frankly, I don’t think they are in the Treasury and No 10.”

Ham said that the target for 92% of patients to be treated within 18 weeks of referral, which has not been met for 18 months, would be the key area of negotiation. But he called for realism, given that around four million people are currently on the waiting list for planned surgery on the NHS.

“Let’s be realistic, it’s a mountain to climb on 18 weeks,” he said. “The number of people on the waiting list is so large now that there is a huge amount of work to be done to clear that backlog. If we can stabilise the position on waiting times, that would be an achievement.”

Given the limited funding available, Gainsbury warned that further rationing was likely if the government took a hard line on waiting times. “If the government insists that waiting time targets have to be met, I’d expect to see fewer patients put on the waiting list in the first place, which is in effect what some CCGs [clinical commissioning groups] have tried to do by implementing clinical thresholds,” she said.

Ham said that NHS England’s warning on the affordability of implementing NICE guidelines may embolden some CCGs to tighten thresholds for treatments. But he argued that national policies in areas such as the prescribing of over-the-counter drugs would at least reduce postcode lotteries.

“In the past it’s been quite tricky, because some of the services locally that CCGs have identified for restrictions have been controversial,” he said. “I think it’s better if this can be done more at a national level, with agreement on what the overall strategy is.”

Gareth Iacobucci, The BMJ

Cite this as: BMJ 2017;359:j5646
THE BIG PICTURE

A centenary of health campaigns

This year marks 100 years of government communications since the establishment of the Ministry of Information in 1917.

In this time, the ministry and its predecessors have produced landmark campaigns designed to help people live healthier lives. To mark the anniversary, Public Health England has produced an online exhibition to showcase both the history of government marketing and the benefits to society when state and other agencies work together.

Among the hundreds of images is the poster (far right), which was distributed by HM Stationery Office to the armed services during the second world war.

The other exhibits include:
1. The 1986 antidrug campaign from the Department of Health and Social Security
2. The Health Education Authority’s 1979 weight loss improves your attractiveness, (and coincidentally your health) campaign
3. Also from the HEA on the dangers of smoking in 1988, a year after the King’s Cross fire had led to more hard hitting antismoking campaigns.

https://publichealthengland.exposure.co/100-years-of-public-health-marketing

Alison Shepherd, The BMJ

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PERSONAL CLEANLINESS

YOU OWE IT TO YOURSELF · YOUR COMRADES · YOUR EFFICIENCY
Neonatal seizures are less common when labour is monitored continuously

Edward Mullins, NIHR academic clinical lecturer, obstetrics and gynaecology
Christoph Lees, reader in obstetrics and fetal medicine, Imperial College London c.lees@imperial.ac.uk

Electronic fetal monitoring is commonly used during labour to detect fetuses at risk of hypoxia and acidaemia. Interpretation is based on subjective assessment and informed by guidance from the International Federation of Gynaecology and Obstetrics and, in the UK, NICE.

A Cochrane review provides clear evidence that neonatal seizures are less common when labour is monitored continuously rather than with intermittent auscultation. Such seizures, which most commonly result from a lack of blood flow and oxygen to the brain (neonatal or hypoxic ischaemic encephalopathy), occur in around 1.8-3.5/1000 live births and are associated with a range of long term motor and cognitive sequelae. These affect not only the function and educational attainment of the child but also their carers and those funding services to support them.

Wrong prioritisation

However, in the UK continuous monitoring is used only for women in high risk labour. This is because 13 trials including more than 37 000 women have not provided evidence that it confers benefit for uncommon outcomes such as perinatal death and cerebral palsy (roughly 3/1000 live births and 1/1000, respectively). As less than 20% of cases of cerebral palsy occur in children with acute intrapartum hypoxic events and death is uncommon, no randomised controlled trials have examined the effectiveness of intrapartum electronic fetal monitoring in reducing these outcomes. Furthermore, intrapartum monitoring would not be expected to reduce the incidence of cerebral palsy because, contrary to widespread belief, it is rarely linked to intrapartum events.

We should be focusing on other forms of evidence relating to the more common outcome with serious long term implications—namely, neonatal encephalopathy. A Dutch birth cohort of 37 735 showed that the births designated as low risk, with women starting labour in primary care under the supervision of midwives, were associated with significantly greater perinatal morbidity and mortality than births designated high risk, with women starting labour in secondary care under the supervision of obstetricians. Continuous fetal monitoring was a key difference in the management of the two groups, low risk women in the first stage of labour often having fetal heart beats checked only every two to four hours.

A US birth cohort of 1 732 211 showed that continuous fetal monitoring was associated with lower early neonatal and overall infant mortality. It has also been associated with a lower rate of neonates with five minute Apgar scores <4 at all gestational ages.

Electronic fetal monitoring increases the rate of instrumental delivery and caesarean section and is likely to increase the rate of intervention in women at low risk if applied universally, although this was only a marginal effect in the US study. However, increased intervention may not be entirely undesirable, given that appropriately timed intervention is likely to avoid neonatal hypoxia, seizures, and perinatal death.

Working blind

Intermittent auscultation is not adequate for assessing fetal heart rate patterns since listening in every 15 minutes for 1 minute may miss important indicators such as decelerations and variability of the fetal heart rate. Failure to use continuous electronic fetal monitoring amounts to a misguided blinding of the clinician to the clinical state of the fetus. Would we allow a patient with possible ischaemic heart disease to have a treadmill test with electrocardiography every 15 minutes? The comparison is apposite: some 5% of fetuses have growth restriction with insufficient placental function, mostly undetected, and are hence at risk of hypoxia during the stress of labour.

Use of the term “normal” labour—always a retrospective diagnosis—has been brought to the fore with the Royal College of Midwives’ change in emphasis from normal births to better births. In this context, intermittent fetal heart monitoring cannot be defended as it is not based on a thorough assessment of the evidence. We do not serve low risk unborn babies well and are possibly committing up to 800 every year in the UK to neonatal encephalopathy and its largely avoidable sequelae. It requires a brave stance, however, to reverse the deliberate demedicalisation that clouds this debate.
Continuous electronic fetal monitoring during labour is a screening test. It aims to identify fetuses at risk of developing intrapartum hypoxic damage. If the test result is positive (ie, the fetal heart rate is abnormal), then a further screening test can be used (fetal blood sampling, which is not without controversy). Ultimately action is then taken to try to prevent the damage—for example, by expediting the delivery.

As a screening test, electronic fetal monitoring performs poorly. It has a poor positive predictive value, even with computerised interpretation of the fetal heart rate. This means that most of the fetuses identified as being at risk of hypoxia are not.

Unusually for a screening test, it has been studied in several randomised controlled trials. A Cochrane review of the data for nearly 37,000 women randomised to electronic fetal monitoring versus intermittent auscultation found no difference in perinatal mortality. The incidence of neonatal seizures in the group given electronic fetal monitoring was lower than in the group that had intermittent auscultation (risk ratio 0.50, 95% confidence interval 0.31 to 0.80), although the overall incidence of seizures in the trials was low (around 1.5-3 per 1000 births). The trial with the highest number of neonatal seizures (12/6530 electronic fetal monitoring versus 27/6554 intermittent auscultation), followed up the babies to the age of 4 years and found no difference in the incidence of cerebral palsy between the groups (12/6527 electronic fetal monitoring v 10/6552 intermittent auscultation).

Risk of harm
Electronic fetal monitoring can lead to harm, with an increased risk of caesarean section (1.63, 1.29 to 2.07), which is not a benign operation. We know that previous caesarean section is a risk factor for uterine rupture, morbidly adherent placenta, massive postpartum haemorrhage, and caesarean hysterectomy. Although these are uncommon, they are associated with high perinatal and maternal mortality, and substantial morbidity. Given that electronic fetal monitoring does not prevent perinatal deaths, the excess of subsequent deaths caused by the increased risk of caesarean section is a major concern.

Babies still die or are damaged because of intrapartum hypoxia. And failure to recognise abnormalities of the fetal heart is still implicated in these deaths. But many of these deaths are multifactorial in origin, and focusing entirely on the fetal heart rate without taking account of other relevant risk factors may create a lack of situational awareness and lead to adverse outcomes.

Screening tests work best in high prevalence conditions. The rarer the condition that is being screened for, the less effective the screening test because the number of false positive results increases relative to the number of true positives. Put more simply, using electronic fetal monitoring routinely in women at low risk will lead to many more unnecessary caesarean sections to potentially prevent each neonatal seizure.

Better strategies
Should we extend the use of electronic fetal monitoring to women at low risk? No. Should we continue to use it as often as we currently do? No. The more we use it, the more harm we do, with little evidence of benefit. Limiting the use of electronic fetal monitoring to the very highest risk labours may be justifiable, but even then the balance of benefits and harms is uncertain.

What, then, should we do? Is there value in continuing to explore the properties of the fetal heart rate to improve the performance of the test? This approach has been tried in more than 54,000 women and has no benefit. Surely we should be looking at other ways of monitoring fetal wellbeing during labour? Advances in “omics” technology to identify more reliable fetal biomarkers of hypoxia, along with advances in engineering and imaging, should help us think of new methods of screening for fetal hypoxia.

In the meantime pressure continues from those with vested interests to increase the use of electronic monitoring. Clinicians should act in the best interests of both the women and the fetuses under their care. Routine use is not in the best interests of either.

Competing interests: See bmj.com.

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Listen to the authors debate the issue in the podcast on bmj.com
Getting It Right First Time (GIRFT) is a national initiative in England aimed at reducing unwarranted variation in care. Interventions to understand how healthcare delivery and outcomes vary are not new. Since the first report on variation in the NHS almost 30 years ago, concerted efforts like the NHS Atlas of Variation series have sought to understand where, and how, care differs from an acceptable norm.

What’s new?
The idea behind the GIRFT programme is to put performance data from multiple sources directly in the hands of clinicians through supportive peer to peer visits, allowing departments to interrogate the data alongside the programme’s leads. Early reports from the pilot, and subsequent scale-up within orthopaedics, indicated potentially huge benefits to the NHS, such as annual savings of £300m just from reducing deep wound infections after joint replacements.

The full evaluation of GIRFT in orthopaedics will not be until 2018, but, thanks to its early promise, the programme is already being expanded across 90% of all NHS secondary care in England, reaching 32 specialty areas backed by £60m of investment. This shows the enthusiasm for what Tim Briggs—creator and now chair of the national initiative—has called a “magic bullet” for the NHS. Despite the appeal of this metaphor, however, there are hazards in assuming that a barrage of data fired at clinicians will necessarily engender improvement across the board. The promise of GIRFT lies in its power as an analytical method rather than its imposition as a one-size-fits-all solution.

The reports that have so far appeared assessing GIRFT, in orthopaedics and surgery, have been cautious. One of the main themes was a call for better data quality and metrics to help a service genuinely to understand whether it is performing well when benchmarked with its peers. Expectations and uncritical reporting also risk moving beyond the evidence, and beyond the conclusions of thoughtful preliminary evaluations. This was exemplified by an interview with Briggs in the Times, with the subheading “Hospitals can save billions, says authoritative report.”

If we allow GIRFT to be simplified as the message that giving clinicians data on how they are performing is enough to improve healthcare, then we will fail to understand what is important about its approach. It is a method, not a solution. It promises a process of appreciative, data led inquiry, to be embraced, experimented with, and adapted. GIRFT is not the sole solution to variation and poor outcomes.

One danger is assuming that merely identifying a problem generates solutions. Briggs has argued that once data are shared and clinicians spoken with, “the solutions become obvious.” But while it seems likely there may be quick wins around pricing and procurement—where almost all variation is unnecessary—best practice is often much less clear cut.

Getting It Right First Time aims to generate certainty about the right thing to do. But, to be effective, this certainty must be accepted and implemented. Even where there is certainty, acceptance and implementation are difficult to achieve. We know, for example, that setting aside beds specifically for patients who have had orthopaedic surgery helps to reduce wound infections. But simply knowing this does not equip struggling providers to successfully implement change across their system.

Benchmark and communicate
Using performance data to drive improvement is not new, as multiple ongoing national NHS audits show. Where GIRFT does represent real progress is in finding ways to benchmark and communicate these data directly to clinical staff, so that individual practitioners, organisations, and the whole NHS can learn from it. It promotes an important paradigm shift towards a safer system by insisting that both clinicians and organisations embrace close scrutiny of their performance. To shift NHS culture in this direction would be a real achievement for GIRFT.

Yet cultural factors responsible for the success of the orthopaedics pilot, such as a charismatic transformational leader and a well circumscribed area of practice, may not apply to other specialties. Unless we pay close attention to the context of the pilot, its successes will be difficult to replicate.

None of this is to diminish the scale of the opportunity. If the newly appointed clinical leads of GIRFT are able to deliver acceptance as well as certainty—and are themselves able to embrace the increased complexity that a deeper understanding of variation will provide—then the opportunity to work with patients and clinicians to reduce unwarranted variation will mean £60m well spent.

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EDITORIAL

The Rohingya people have resided in Myanmar since before 1799, but in 1982 the state stripped them of citizenship under the pretext that they were “illegal” migrants from Bangladesh. Decades of systematic persecution have meant the Rohingya have been excluded from education and healthcare, subjected to restrictions on births and marriages, and forced to relocate to camps for internally displaced people. As a consequence, the Rohingya have an acute malnutrition rate 50% higher than non-Rohingya residents in Rakhine state, and diarrhoeal illness rate five times greater than non-Rohingya residents. As a consequence, the Rohingya camps for internally displaced people. marriages, and forced to relocate to

The global health community has a responsibility to act. First, it must rapidly increase aid for arrivals and camp residents in Bangladesh. Amid lack of shelter, food shortages, and inadequate healthcare, poor sanitation and shortages of potable water are contributing to severe dehydration and diarrhoea. In 1978, an estimated 10 000 Rohingya, 7000 of whom were children, died from starvation and diarrhoeal illness. To avoid history repeating itself, sufficient resources must be allocated to implement preventative water, sanitation, and hygiene and nutrition interventions, including the building of latrines, safe water storage, distribution of ready-to-use food, and micronutrient supplements.

Responsibility to act

Second, Rohingya must be kept from harm, especially while in flight. In particular, unaccompanied minors must be protected from sexual violence, including sexual exploitation, forced child marriage, and recruitment as military sex slaves. Survivors will require shelter, clinical care, and mental health support. Health professionals along with humanitarian agencies in Indonesia, Malaysia, and Thailand must advocate for the safe reception of Rohingya arriving by boat. All must protest anti-refugee responses, such as the potentially fatal naval actions in 2015 that pushed Rohingya back out to sea—which were ultimately stopped after an international outcry.

Third, as Bangladesh and Myanmar consider a verification process to return refugees, the Rohingya’s safety, health, and wellbeing must be prioritised, particularly in light of their potential return to camps for internally displaced persons in Myanmar. There are few places to which Rohingya can return. Many of their villages have been razed and reclaimed by the state. Health professionals must monitor repatriation and advocate for the Rohingya’s group identity to be recognised. Repatriation should be conditional on the guarantee of their safety and access to food, ensured by international peacekeepers.

Fourth, agencies must organise data collection and information sharing, so abuses can be documented and care needs be understood and met. Data driven evidence is essential for current advocacy, for future potential criminal prosecution, and as an accurate historical record.

There are now as many Rohingya living in dire conditions in Bangladeshi camps as there are left in Myanmar. These people, and the more than 300 000 living across southeast and south Asia, must receive urgent health prevention measures to protect them from what will surely be epidemics resulting from their exodus.

Support The BMJ Christmas 2017 appeal for Médecins Sans Frontières, bringing medical volunteers to the world’s neediest people: donate at www.msf.org.uk/bmj
Disruptive technologies that are making cancer care more patient centred

If diagnostics and digital advances will help patients become equal partners in their care, where will that leave doctors’ role? *Jacqui Wise* reports

*What “disruptive” technologies could help deliver patient centred care? A recent cancer conference in London, organised by the Economist magazine, pondered this question. Examples include patient feedback websites and smartphone apps that make doctors engage with patients’ preferences; artificial intelligence that can aid personalised medical decision making; and point-of-care tests that are shifting screening out of the doctor’s surgery and into the community. Indeed, NHS England chief executive, Simon Stevens, used the conference to announce the expansion of a pilot programme offering lung cancer screening in the community.*

Advocates for these innovations argue that they can empower patients, improve communication, promote continuity of care, and push up standards. However, there is a risk that new technologies could prove a distraction for busy doctors and possibly lead to overtreatment and increased workload.

**Rate your doctor**

Neil Bacon, chief executive and founder of iWantGreatCare, a cloud based technology platform that allows patients to review doctors, hospitals, and medicines, told the conference: “Patients are used to going online to find information about restaurants and hotels, but try looking up information about a neurosurgeon who is going to operate on your child. It is very difficult.”

“Our children will look at us and laugh that healthcare has taken so long to catch up. It is happening, but not fast enough.” He added: “There is a shift of power towards patients. There is always resistance to change, but the walls will tumble. Citizens won’t accept a lack of transparency anymore.”

The NHS Cancer Vanguard programme, which was established in 2015 to test new models of cancer care, has now partnered with iWantGreatCare. The system is being used by 45 NHS organisations in London and Manchester to collect real time patient feedback at key points in the cancer care pathway. The aim is to use this feedback when redesigning services, putting patient experience at the heart of service improvement. “If we do not listen continuously to patients and their caregivers, we will never learn and improve the standards of cancer care,” says Bacon.
Bacon says patients trust the views and opinions of other patients. He dismisses those who worry about negative reviews, saying that most reviews are positive and that his organisation uses technology to stop fraudulent reviews. He says there should be more pressure on doctors to be patient centric. “When doctors are rated their morale goes up,” he adds.

England’s national cancer strategy, *Achieving World Class Outcomes*, published in 2015, said that patient experience should have the same importance as clinical effectiveness and safety. It called for patients to be properly informed and empowered to be equal partners in their care. “We have the opportunity to revolutionise the way we communicate with and the information we provide to cancer patients, using digital technologies,” it said, pointing out that more than two thirds of adults own a smartphone and that patients could benefit if all information shared with them during consultations was made available to them electronically.

In its implementation plan published in 2016, NHS England pledged to put patient experience on a par with other patient outcomes. There has been some progress on this with the Cancer Patient Experience Survey and the Cancer Dashboard, an online resource to help identify priorities for improvement. NHS England says it is also working on its wider digital revolution programme to ensure that all patients have online access to all test results and other communications with secondary and tertiary care providers by 2020.

**Apps in the NHS**

Recent years have seen a sharp rise in the number of health apps available for smartphones, several of which are being tested in the NHS. Trials of apps such as myCOPD, for example, have shown that they can help patients manage their conditions with less reliance on general practice and hospital appointments.

The conference heard about another app, Andaman7, which allows users to store their health records securely and share them with family members and doctors. Vincent Keunen created the app after he developed leukaemia and his son had bone cancer. It is being tested at CHU-Liège, a university hospital in Liège, Belgium, where any patient can receive documents from the hospital to their smartphone. He told the conference that being able to share his medical data with his doctor improved communication and speeded up diagnosis.

In September, the health secretary, Jeremy Hunt, said that every patient in England should be able to access their medical records, book an appointment with a GP, and order repeat prescriptions through an app by the end of 2018. The scheme is being piloted in several practices countrywide.

Advances in informatics can help to improve communication between various departments on the cancer pathway. Varian Medical Systems manufactures medical devices, including for proton beam therapy, but it has also developed tools that connect hospital or clinic data, records, and patient information through a single platform.

Sukhveer Singh, vice president of oncology continuum solutions at Varian, said that this has many advantages. “We treat patients as users of our platform alongside doctors and nurses, allowing real time communication. Lots of patients want to be able to keep an electronic diary and be able to share it with doctors, so how a patient is feeling can be looked at alongside the numbers.”

Technology proponents see a healthy future for the use of artificial intelligence (AI) in healthcare. For example, IBM Watson Health is using a supercomputer with artificial intelligence to digest massive amounts of data from doctors’ notes, research studies, and clinical guidelines and claims it can identify cancer treatments personalised to each patient.

Dusty Majumdar, vice president of the company, said it was a myth that such technologies will replace doctors but said it can help tackle the huge variability in cancer care. “There is a buzz out there that AI will replace doctors, but that’s not our belief. We will instead offer radiologists the chance to put joy back into their jobs. And to get better outcomes. AI won’t replace
radiologists, but radiologists who use AI will replace radiologists who don’t use AI,” he told the conference.

**Advances in screening**

To improve early diagnosis the NHS is moving more cancer screening out of the doctor’s surgery and into the community. A pilot scheme that offers smokers and former smokers computed tomography scans in supermarket car parks quadrupled the early diagnosis rates for lung cancer in Manchester. The scheme is being rolled out throughout north Manchester, and some other cancer alliances, charged with local implementation of strategy, are following suit.

The NHS is also planning to introduce faecal immunochemical testing (FIT) into the bowel screening programme next year. The home testing kit will be sent to everyone aged 60 to 74 every two years. The FIT test is easier for people to carry out at home because it requires only one faecal sample rather than the six needed for faecal blood testing. It remains to be seen how acceptable the public finds the test, but NHS England expects it to increase the take-up of bowel screening by about 7%.

However, Corrie Drum, policy adviser for Cancer Research UK, argues that expansion of screening programmes must be matched by a commitment to increase the diagnostic workforce. “It’s vital that there are enough staff in the NHS to carry out and interpret tests for cancer, including more staff who do colonoscopies, if we’re to make FIT even better in the future.”

In the future non-invasive, more user friendly tests may have an even greater role. Owlstone Medical has developed a breath test to measure volatile organic compounds that are biomarkers for cancers. The NHS is funding the LuCID clinical trial with 4000 patients at 26 sites to evaluate the diagnostic accuracy of the test for lung cancer. Billy Boyle, cofounder of the company, told the conference, “The nature of the test matters. For example, patients don’t like colorectal screening. A big advantage of a breath test is its patient acceptability.”

Sometimes new technology adds to a GP’s workload but produces only limited benefits. A recent pilot study into one form of electronic consultation, eConsult, found that most patients still wanted to see their GP in person after an online consultation. Helen Stokes-Lampard, chair of the Royal College of GPs, said, “Innovations must be implemented in the best interests of patients as a whole—and in ways that alleviate pressures across the NHS, not potentially add to them. It’s a myth to say that because we are making greater use of technology that we must be saving resources.”

Some commentators argue that the NHS hasn’t yet mastered even basic technological advances. Ali Stunt, chief executive of the charity Pancreatic Cancer Action, said communication between doctors and patients and between different parts of the cancer care system was a major problem. “Why in 2017 are doctors still having to write to each other? Why not email? Technology has moved on.”

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