this week

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RICHARD H SMITH

GPs vote to take home visits off contract

GP leaders in England have called for an end to their contractual responsibility to carry out home visits, after a tense vote at their annual conference in London.

After a passionate debate, England's local medical committee (LMC) representatives passed a motion that said that GPs "no longer have the capacity to offer home visits" and called on the BMA's General Practitioners Committee (GPC) for England to negotiate contract changes to reflect this.

The motion was voted on in three parts, all of which were carried. The first section to "remove the anachronism of home visits from core contract work" narrowly passed, with 54% voting in favour and 46% against.

Three quarters (74%) of representatives backed a strand urging the GPC to negotiate a separate acute service for urgent visits, while 90% backed a demand that any such change be "widely advertised" to patients.

Andy Parkin of Kent LMC, who proposed the motion, insisted the move would not disadvantage the most frail and vulnerable patients. "Moving away from routine home visits would improve the care of all our patients by gaining us that most precious and rare commodity—time," he said. "No other country has on-demand home visits. This motion gives the GPC a mandate to remove the expectation that home visits are an entitlement regardless of clinical need."

Sarah Matthews, from Coventry, was among the delegates who spoke against the motion, warning it would "sell the heart and soul of our profession away." And Annie Farrell, from Liverpool, argued that home visits were more important than ever with more patients living longer.

Also opposed was Ian Morris from Devon, who said, "We learn a lot about a patient from seeing them in their own home. We would be losing an important part of our professional identity."

But Parkin said, "This motion doesn't take away your choice to see patients at home who need to be seen. We do not have the capacity, the staff, or the time. Even if it can't be negotiated, this sends a clear message to the government that we need help."

The vote was carried after several GPs highlighted the need to "send a message." Brian McGregor, from North Yorkshire, said, "We are getting increasing demand, year on year. This isn't about just home visiting, this is about workload, and about when to say 'enough is enough.'"

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;367:l6663

COMMENT, page 360

Andrew Parkin, from Kent LMC, who proposed the motion, said it sends a "clear message to government" that GPs need help

LATEST ONLINE

- GP who downplayed symptoms of boy who died from Addison's disease is suspended
- Disgraced tracheal transplant surgeon is handed 16 month prison sentence in Italy
- US charity pays $4m to settle allegations it paid patients kickbacks from drug makers

SEVEN DAYS IN

Royal college calls for a public and mandatory register of doctors' interests

The Royal College of General Practitioners will call on the GMC to ensure all registered doctors have declared their conflicts of interests, as part of a mandatory scheme.

The college council "overwhelmingly" passed a motion on 23 November that said declaring interests must be a condition of registration and that declarations must be reviewed "at least annually" and be held on a publicly available register.

The council said it believes that all healthcare professionals should make similar declarations, and any implementation costs should be met by the government.

The motion was proposed by GP Margaret McCartney (left), who has long argued for such a scheme. Speaking at the RCGP conference in 2018, she said, "We have to show that we are deserving of trust. We have to take the lead and say we want to get this better. Now has to be the time to sort it out."

The GMC has acknowledged such calls previously but has not indicated it will act. A spokesperson said the law would need to change to make declarations mandatory. "We have been pushing for legislative change for some years now, including having the flexibility to gather certain types of information," the spokesperson added.

Elisabeth Mahase, *The BMJ* Cite this as: *BMJ* 2019;367:l6695

Cervical screening

Number of women tested rises slightly

Nearly three quarters (71.9%) of the women in England aged 25 to 64 who were eligible for cervical cancer screening had an adequate test. This is up 0.5 percentage points on the previous year from 71.4%, showed figures from NHS Digital. Altogether, 4.41 million women were invited for screening (down 1% on 2017-18), and 3.43 million were tested (up 7.7%).

Social care

Deaths while waiting for support are "shameful"

In the 30 months between the last election and the next an estimated 74 000 people will have died while waiting for social care in England, Age UK reported. It estimated that 1.72 million unmet requests for care and support will have been made by older people from 8 June 2017 to this 12 December. Caroline Abrahams, Age UK director, called the statistics "shameful" and emphasised that social care was not a "nice to have" option but a "fundamental service."

Overseas news

Australia urged to ban dementia control drugs

Campaigners from Human Rights Watch and Aged & Disability Advocacy Australia wrote to the country's ministers of health and aged care urging them to immediately revise regulations and prohibit the use of drugs to control behaviour in people with dementia. Bethany Brown, a researcher at Human Rights Watch, said, "The government has recently received three major reports on the horrific effects of chemical restraint in aged care. The ministers should take immediate and decisive action by banning chemical restraint and requiring real support for older people with dementia."

J&J loses class action over vaginal mesh

More than 1350 women won a seven year class action in Australia against the drug company Johnson & Johnson over harm they sustained from its transvaginal mesh and tape devices. A Federal Court judge, Anna Katzmann, ruled that J&J's subsidiary Ethicon had sold the products without warning women or doctors of the gravity of the risks and had been negligent in rushing them to market without proper testing. Reading from her 1500 page summary, Katzmann said that much of the information the company provided about the devices was "inaccurate" and that at times it had made "false representations."

Philippines bans e-cigarettes and vaping

The Philippines will ban the sale and import of e-cigarettes and will outlaw public vaping, said President Rodrigo Duterte (below), a week after the country's health department announced its first case of vaping lung injury, in a 16 year old girl. Duterte is known for his draconian approach to substance abuse, which has led to thousands of violent deaths of drug users. The former smoker, who announced last month that he has myasthenia gravis, banned public smoking nationwide in 2017 and said this year that cigarette smokers should be "exterminated."

Swine flu vaccine

Case of Irish student with narcolepsy is settled

A claim against GlaxoSmithKline and the Irish state by a 16 year old girl, who developed severe narcolepsy after being vaccinated against swine flu with Pandemrix, was settled for an undisclosed sum. Trial documents showed Pandemrix had a higher rate of side effects than GSK's Arepanrix, which was used in Canada. More than 1000 people in Europe who were given Pandemrix are thought to have developed narcolepsy.

Exercise

Most adolescents "are not active enough"

Some 85% of girls and 78% of boys are physically active for less than an hour a day, a study of 1.6 million 11-17 year olds from 146 countries showed. Action was needed at many levels including education, urban planning, and road safety, the authors wrote in *Lancet Child and Adolescent Health*.

MEDICINE

Obstetrics

One in three maternity doctors feels "burnt out"

A third of UK doctors working in obstetrics and gynaecology are experiencing burnout that could affect their wellbeing and treatment of patients, a survey of 3073 doctors suggested. Researchers at Imperial College London, in collaboration with KU Leuven University in Belgium and the Royal College of Obstetricians and Gynaecologists, found high levels of long term stress and overwork, as 36% (1116) of respondents met the criteria for burnout. Trainees were particularly susceptible, with 43% (580/1357) meeting the criteria for burnout.

36% burnout

Long term stress and overwork affect more than a third of obstetricians and gynaecologists

Experts critical of Indian ministry's oxytocin advice

Doctors and maternal health experts in India questioned the scientific rationale and ethics of an Indian health ministry announcement that advised obstetric staff to delay giving oxytocin to women after childbirth until the uterus has expelled the placenta. The experts emphasised that the advice deviated from World Health Organization guidelines practised worldwide, including in India. These recommend that oxytocin should be administered within a minute of birth to lower the risk of postpartum haemorrhage. The health ministry included its suggestion on oxytocin in an advisory notice to health officials on 6 November.

Polio

Vaccine derived cases are now most common

Cases of polio paralysis arising from vaccination are now more common than cases caused by wild poliovirus, experts said. The World Health Organization reported that nine recent polio cases were caused by the vaccine in Nigeria, Congo, the Central African Republic, and Angola. In rare cases the live virus in oral polio vaccine can mutate into a form capable of sparking new outbreaks. The Independent Monitoring Board, a group set up by WHO to assess polio eradication, warned this month that vaccine derived polio virus was "spreading uncontrolled in west Africa" and "raising fundamental questions for the whole eradication process."

Air pollution

Report shows health impact in UK cities

Living near a busy road can stunt lung growth in children by as much as 14%, warned a report backed by health and environmental groups that called for tougher air pollution laws in the UK. Researchers from King's College London analysed 13 health outcomes in people living in high pollution areas and compared them with the general population in nine UK cities and four in Poland. They pooled data from previously published studies and meta-analyses, together with air pollution measurements from roadside monitoring stations.

Cite this as: *BMJ* 2019;367:l6680

SCREEN TIME

Nearly 80% of 2 year olds and 95% of 3 year olds are exceeding recommended limits on screen exposure

[JAMA Pediatrics]

SIXTY SECONDS ON . . . STENTS

SURELY STENTS ARE THE FUTURE

So you might think if your acquaintances include a lot of interventional cardiologists. The clue's in their name.

THEY'RE PREDISPOSED TO INTERVENE?

Exactly.

AND THEY'RE WRONG?

A big study indicates that in some cases they may be. The ISCHEMIA trial randomised more than 5000 patients with stable heart disease to either invasive therapy (stenting or a bypass) or to drugs. After three years the outcomes were very similar.

WHAT WERE THEY?

Slightly fewer of the intervention group (13.3%) had heart attacks, cardiac arrests, or hospital spells for unstable angina than in the medically treated group (15.5%), but the difference wasn't statistically significant.

SO, LOTS OF PEOPLE ARE HAVING INTERVENTIONS WITH NO BENEFIT?

Judith Hochman of New York University, the study chair, said, "For those with mild or no chest pain, there's really not a role for immediately stenting."

IS THIS NEW?

The study is, but the conclusions aren't. Earlier research had shown that drug therapy works well but didn't have a lot of effect. Intervention has become the default option. Cutting out unnecessary stenting could save the US healthcare system $570m (£444m) a year, estimates study co-chair David Maron.

WILL CARDIOLOGISTS CHANGE?

First, the study will have to be published—so far it's only been presented at the annual meeting of the American Heart Association. Publication is expected early next year, when *The BMJ* will report more fully. And it looked at only a subset of the patients cardiologists see. Those who have had a heart attack will still get interventions, and those with pain may opt for them. So the impact will be blunted.

INTERVENTIONISTS WILL FIGHT BACK?

I didn't say that. But telling a cardiologist "Don't just do something, stand there" hasn't previously cut much ice.

Nigel Hawkes, London

Cite this as: *BMJ* 2019;367:l6666

NHS must apologise for "offensive report" on practice fraud

The BMA's General Practitioners Committee must raise a formal complaint with NHS England over a bribery and fraud report published earlier this year, which suggested that economic crime in general practice cost the NHS £88m a year.

The motion, which was passed unanimously, condemned the report, which it said had implied "widespread fraud" in general practice. It also called for the GPC to work with NHS England to tackle its "offensive culture" that "allowed general practice to be referred to in this way."

Anu Rao (left), of Leicestershire and Rutland, the proposer, said, "This is nothing but another insult to the already demoralised profession. The shocking part is that NHS England do nothing when actual, evidence based fraud happens."

THIS IS NOTHING BUT ANOTHER INSULT TO THE ALREADY DEMORALISED PROFESSION

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;367:l6665

BMA sexism: GPs call for "action not words"

Local GP leaders have demanded that the BMA's General Practitioners Committee publish a formal action plan for tackling sexism and harassment by next May in response to the damning report into the discriminatory culture at the association.

The independent review by Daphne Romney QC, published last month, reported a culture in which female doctors and staff at the BMA had been bullied, undermined, and in some cases sexually harassed. The BMA's governing council met on 13 November to consider the report and unanimously agreed to act on all 31 recommendations.

GPs also voted unanimously to accept the report and to demand that the GPC publish its own formal action plan, with timescales, before the LMC's UK conference next May.

The motion was proposed by Laura-Jane Evans from Dorset, who called for "swift, decisive action" from the GPC. "What we need now are actions not words," she said. "This is an opportunity to embed real change in our organisation and to become more equal and inclusive."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;367:l6681

No one is really clear why medicine shortages are worsening, but what is clear is that it's causing suffering for patients and adding to our workload
Ray McMurray, Shropshire

GPs call for urgent action on drug shortages

GPs have demanded the BMA's General Practitioners Committee for England take "urgent action" to mitigate the effects of drug shortages. The motion, which was passed in full at the Local Medical Committees England conference, called for GPC England to recognise the "adverse impact" of shortages on patients and on GPs' workload.

The committee was instructed to secure extra funding to support general practices in dealing with current shortages and explore how to make "pharmacists responsible for identifying appropriate and available alternatives."

Ray McMurray, a GP from Shropshire LMC, who proposed the motion at the London conference on 22 November, said, "The shortage of medicines has become a full-on permanent hot flush for many of our patients who are struggling to get their HRT.

"My personal drug squad list of familiar HRT medicine is limited. But even using the online, real time tracker programs to try to find a suitable and available alternative to discuss with my patients takes time. Time I do not have."

He added, "And it's not just HRT: it's antiepileptics, antihypertensives, diabetic medication, and even some non-steroidals. For some pharmacists, sending patients back to their GP is also a last resort—they too have spent time hunting around. They also have to monitor an ever changing price concession list of generics not readily available at drug tariff prices.

Pension reprieve: will the new scheme work for you?

Earlier this month NHS England announced a temporary scheme to allow doctors to work extra hours over winter, with the promise that the NHS would reimburse them for any additional tax they accrued on their pension as a result.

Under the scheme, hospital doctors and GPs who reach the annual allowance limit in 2019-20 can choose a "scheme pays" option. Mark Skellum (right), a partner at chartered accountants Ballards LLP, explains how the scheme will work

What is the "scheme pays" option?
It is a way to defer an annual allowance liability until you draw your pension. Rather than having to pay through your tax return, the scheme pays option means the NHS pension scheme will settle the liability on an individual's behalf. While this gives the individual an immediate cash flow advantage, compound interest is charged on the liability until the pension is taken.

Will I have to pay the interest if I opt for scheme pays?
In a letter sent to medical unions and royal colleges, Simon Stevens, NHS chief executive, said that individuals would be "fully compensated" for the effect of the scheme pays deduction, so it's hoped that compensation would include any interest charged. However, this isn't stated in the information released so far.

"No one is really clear why medicine shortages are worsening in the UK, but what is clear is that it's causing suffering for our patients and adding to our workload."

Many GPs spoke about their own experiences of shortages. Abel Adegoke, from Wirral, said, "Last week alone I spent several hours ringing pharmacists, ringing irate patients and families, just to make sure that, as a GP, I fulfilled my duty . . . I don't think our economy should be going through this. Frankly speaking, it is a shame."

Not a new problem

Others highlighted that this was not a new problem. Martin Harris, a GP from Barnet, said, "I wrote about this issue in *The BMJ* in May 2015. Four and a half years later it's now being blamed on Brexit. Of course, Brexit has not helped the situation—it has accentuated it. There are several different problems involved here."

The only opposing speaker was the GPC's clinical and prescribing deputy lead, Tom Yerburgh, from Gloucestershire, who spoke against a part of the motion that called for pharmacists to be given the power to dispense an equivalent preparation or dosing regimen without needing to ask the GP for a prescription amendment.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2019;367:l6661

MICHELLE DRAGE, CHIEF EXECUTIVE, LONDONWIDE

"I have experienced these shortages as a patient, let alone as a GP.

"GPs are tearing their hair out, and so are the pharmacists.

"It is appalling that we have shortages of medicines in this country, whatever the reason. We are talking about anaphylaxis, epipens, and drugs that enable people to live their lives. HRT is a prime example, but there are many others"

ABEL ADEGOKE, SECRETARY, WIRRAL

"I had to change HRT for one patient five times because it wasn't available. It does take up a lot of time.

"I know the government knows about it and we have let them know how irritating it is. Maybe [they could] empower the pharmacies to do some things to help GPs, rather than just saying 'go back to your GP'"

TRACEY VELL, CHIEF EXECUTIVE, MANCHESTER

"Nobody really seems to be unpicking the root of the problem. Is it about transport, is it about the EU, is it about other things?

"We just need to get to the bottom of it, because it is taking us too much time to deal with"

BOB MORLEY, SECRETARY, BIRMINGHAM

"It is an absolutely horrendous issue, patients simply can't get the medications they need.

"There are major shortages of HRT, antidepressants, antihypertensives, painkillers, drugs for arthritis, all sorts.

"This needs to be solved and quickly. It's creating huge additional work and frustration for GPs"

VIOLAINE CARPENTER, HERTFORDSHIRE

"This is an issue we are facing on a daily basis. It's mainly HRT, but it's five, six, 10 times a day that we just can't get the drugs.

"We don't really know what is going on, which makes it harder to explain to our patients. Patients are wanting to stockpile their medication, but we can't let them do that. It's taking up time we should be spending looking after our patients"

As a consultant who has given up extra work because I was concerned about a large tax bill, could the scheme work for me?

Yes, it could. The scheme aims to encourage consultants to take on extra commitments. But the finer details are not yet known, and the scheme could have unintended tax consequences if it is not well designed.

Can I now take on extra work?

In principle the scheme will enable this, but without suitable firm assurances—including detail on how it would operate—it might still be hasty to jump straight back into extra hours, particularly as there will be changes of government before many doctors retire.

I am a GP. Could the scheme work for me?

The scheme has a direct effect on NHS employees, but the position regarding non-employee members of the NHS pension scheme is not as straightforward.

NHS England said it recognises the significant contribution made by GPs in times of winter pressure and that it will be working through a detailed implementation mechanism with representative bodies to achieve the appropriate benefits.

It would seem, therefore, that the intention is to help GPs, but without more detail it is not possible to confirm whether the scheme would be beneficial at the present time.

Why is NHS England advising I use the scheme and not pay my tax?

Using the scheme ensures the liability is paid, but NHS England won't have to pay out until the doctor retires. This will help it to balance its books, albeit with a mounting future liability. Using any other mechanism to offset the allowance charge would most likely have other consequences.

I opted out of the NHS pension scheme. Should I opt back in?

NHS England's own FAQs web page says that opting back into the scheme would be encouraged. But every member's circumstances will be different, and it would be advisable to take professional financial advice.

Will this scheme solve the NHS pension scheme's problems?

Regrettably, no. The scheme has been implemented only for 2019-20 and does not solve the over-riding issues. It is a short term fix while we await any potential long term solution.

Is there a viable long term solution?

Realistically, it is highly unlikely the government will make any major changes to the annual allowance. It has previously stated that there would be no special cases in connection with implementation of the charge.

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2019;367:l6698

Maternity care failings in Shropshire stretch back four decades

A leaked internal report about maternity care at Shrewsbury and Telford hospitals has highlighted failings that led to deaths and injuries of babies and mothers over 40 years. **Jacqui Wise** reports

Bereaved families were treated with a distinct lack of kindness
Leaked Donna Ockenden report

What is this leaked report?
Midwife Donna Ockenden is leading an independent review of maternity care, including cases of serious and potentially serious concern, at Shrewsbury and Telford Hospital NHS Trust, which runs the Royal Shrewsbury Hospital and Telford's Princess Royal. The report, leaked to the *Independent* newspaper, appears to be a confidential status update submitted last February, produced at the request of NHS Improvement and not intended for publication.

When was the review set up?
In 2017, by the then health secretary for England, Jeremy Hunt, in response to a campaign led by two sets of parents: the Stanton-Davieses, whose daughter Kate died shortly after birth in 2009, and the Griffiths, whose daughter Pippa died shortly after birth in 2016.

What is the scope of the inquiry?
It was initially asked to examine 23 cases in which failings in maternity care were alleged. In August 2018 its scope was expanded to look at 40 cases between 1998 and 2017, then later to 100 cases. The figure has now grown to more than 270, covering 1979 to the present. In June 2019 NHS Improvement asked for all cases since 1998 of deaths, stillbirths, and babies born with brain damage to be looked at, but said not all cases were necessarily the result of substandard care.

What does the leaked report say?
It highlights 42 deaths of babies (three deaths during pregnancy, 22 stillbirths, and 17 deaths after birth) and of three mothers at the trust between 1979 and 2017. There were also 47 other cases of substandard care and 51 cases of cerebral palsy or brain damage.

It says that there were repeated clinical errors, compounded by substandard follow-up investigations that failed to ensure that lessons were learnt. Bereaved families were treated with "a distinct lack of kindness and respect," with examples including deceased babies given the wrong names in writing or being referred to as "it."

There was a longstanding lack of transparency, honesty, and communication with families when things went wrong. Many grieving families were wrongly told that they were the only ones affected and that lessons would be learnt.

The report identified specific failures, including staff failing to realise that labour was going wrong, inadequate monitoring of fetal heart rates during labour, poor risk assessment during pregnancy, and babies left brain damaged from group B streptococcal infection or meningitis that could have been treated with antibiotics.

When will the final report be published?
A fuller investigation into avoidable baby deaths at the trust is continuing, but it is not known when the final report will be published. Ockenden said she had listened to the families involved, who made it very clear that they wanted one, single, comprehensive independent report covering all known causes of potentially serious concern.

When were concerns first raised?
The leaked report says that regulators were aware of problems as far back as 2007, when the Healthcare Commission, a forerunner of the Care Quality Commission, highlighted concerns about injuries to babies.

What has the Care Quality Commission done?
Its latest inspection report, published in November 2018, rated the trust as inadequate and placed it in special measures. It made several recommendations regarding maternity services, including a review of the processes concerning women at high risk and of its policy on reduced fetal movement.

Have there been previous reviews?
In July 2017 the trust commissioned the Royal College of Obstetricians and Gynaecologists to assess its maternity services as part of a non-regulatory and advisory review. The college submitted its report in December 2017, making 37 recommendations to ensure improvements. The college criticised the trust for not publishing this report until July 2018.

Could doctors be struck off?
The GMC has said that it is in contact with the trust and has asked NHS England and NHS Improvement for details of any concerns about individual doctors. Anthony Omo, the GMC's general counsel and director of fitness to practise, said, "Where we receive details of any such concerns we will take appropriate action to protect patients and public confidence in doctors. All doctors have a responsibility to take action if they are aware that patient safety may be put at risk."

The Royal Shrewsbury Hospital was put into special measures in 2018

Rhiannon Davies's daughter Kate died shortly after birth in 2009

Will the trust face corporate manslaughter charges?
West Mercia Police has said it is liaising with the inquiry and awaiting its findings before it considers any criminal proceedings.

What is the trust's response?
Paula Clark, the trust's interim chief executive, said, "I would like to reassure all families using our maternity services that we have not been waiting for Donna Ockenden's final report before working to improve our services. A lot has already been done to address the issues raised by previous cases. Our focus is to make our maternity service the safest it can be. We still have further to go but are seeing some positive outcomes from the work we have done to date."

Is this the UK's biggest maternity scandal?
It seems so. Until now the worst ever maternity scandal was at University Hospitals of Morecambe Bay Trust. A 2015 investigation found significant failures of maternity care at Furness General Hospital in Cumbria that may have contributed to the deaths of three mothers and 16 babies between 2004 and 2013. Different clinical care in these cases would have prevented the death of one mother and 11 babies, the report concluded.

Jacqui Wise, London

Cite this as: *BMJ* 2019;367:l6656

The leaked report says that as far back as 2007 the regulator highlighted concerns about injuries to babies

End out-of-area GP registration, say protesters

GPs and patients took to the streets of Tower Hamlets in east London last week to protest against further expansion of the "digital first" GP at Hand service, which they say will disrupt the care of patients most in need in the area.

Health campaigners are increasingly concerned about the activities of the Babylon owned internet service, which has attracted an estimated 60 000 patients in London and Birmingham. On 21 November protesters marched from the Newby Place GP surgery, where GP at Hand used to have a room, to Canary Wharf, where the service hopes to establish a new clinic. A billboard at the station will be seen by thousands of people who flock to London's business district every weekday.

Jackie Applebee, a local GP, told *The BMJ* that NHS England had proposed that GP at Hand would be able to acquire physical premises if it signed up 1000 patients. She argued that this would bypass the normal procurement criteria for a contract to provide GP services.

Cherrypicking

"The advertisement is targeting young, fit, and wealthy people—capitalising on the GP at Hand model to cherrypick the healthiest patients while leaving those who are chronically ill with fewer resources," she told *The BMJ*. "The scheme has too many negative unintended consequences, such as being good for people who are computer literate while taking choice away from older, complex patients who cannot use an app."

Applebee called on the LMC annual conference, held in London on 22 November, to abolish out-of-area patient registration schemes. "I'm not anti-tech," she said. "But this type of scheme is really not equitable at the moment and has to be stopped."

Zosia Kmietowicz, *The BMJ*

Cite this as: *BMJ* 2019;367:l6667

CAMPAIGNERS are increasingly concerned about the activities of the Babylon owned GP at Hand, which has attracted an estimated 60000 patients in London and Birmingham

MARK THOMAS

CHRISTMAS 2019 APPEAL

Help WaterAid turn on the taps worldwide

The charity brings safe drinking water and toilets to millions of the poorest people worldwide. Please give generously

Seven year old Toky and his friends wash their hands at Manantenasoa primary school in a remote village in Madagascar.

In schools like his, health centres, and communities in 28 poor countries, the charity WaterAid implements sustainable schemes that provide water for toilets and handwashing and trains local people to manage them. WaterAid also works with governments to invest in these basic services.

In Madagascar nine in 10 people lack access to a decent toilet. Before WaterAid's intervention, Toky's school, in the Fihaonana region, had no safe drinking water, and pupils had to defecate in the open. In the nearby village of Antsipary, the midwife used to work with no clean water.

A 10th of the world's population, 785 million people, lack close access to clean water, and one in four, two billion people, have no decent toilet. A quarter of the world's health centres have no clean water, and a fifth lack decent sanitation. Every minute a newborn baby dies from infection in an unclean environment lacking safe water, the charity says.

Clean water, good sanitation, and hygiene are essential to prevent and control outbreaks of deadly diseases such as cholera. Preventing infectious disease can reduce the need for antibiotics, potentially minimising antimicrobial resistance. With easy access to water and toilets, women and girls are at less risk of violence.

In 2018-19 WaterAid supplied 1.4 million people with clean water and nearly as many with toilets, and supported 827 schools and 149 healthcare facilities.

Donations from *BMJ* readers would support more people to live healthier lives. The charitable Alchemy Foundation will double every donation from *BMJ* readers up to £25 000. For a more significant gift, please email philanthropy@wateraid.org.

Richard Hurley, features and debates editor, *The BMJ*

Cite this as: *BMJ* 2019;367:l6703

WATERAID/ ERNEST RANDRIARIMALALA

Support WaterAid in providing clean water and sanitation in the world's poorest communities

WaterAid

DONATE ONLINE www.wateraid.org/uk/donate/the-bmj

BY PHONE: 020 7793 4594

Please return to: *The BMJ Appeal, WaterAid, York House, Wetherby Road, Long Marston, York YO26 7NH*

Title .....

Forename .....

Surname .....

Address .....

.....

Postcode ..... Telephone .....

Here is my gift:

☐ £60, which is enough to buy a clean water tank for a school in a country like Burkina Faso

☐ £144, which is enough to install handwashing stations in one school in a country like Malawi

☐ £288, which is enough to build two toilets in a country like Ghana

☐ £.....

I enclose a cheque /charity voucher made payable to WaterAid **OR** I authorise WaterAid to debit my Visa / Mastercard / Maestro / CAF card below:

Cardholder name .....

.....

Card number

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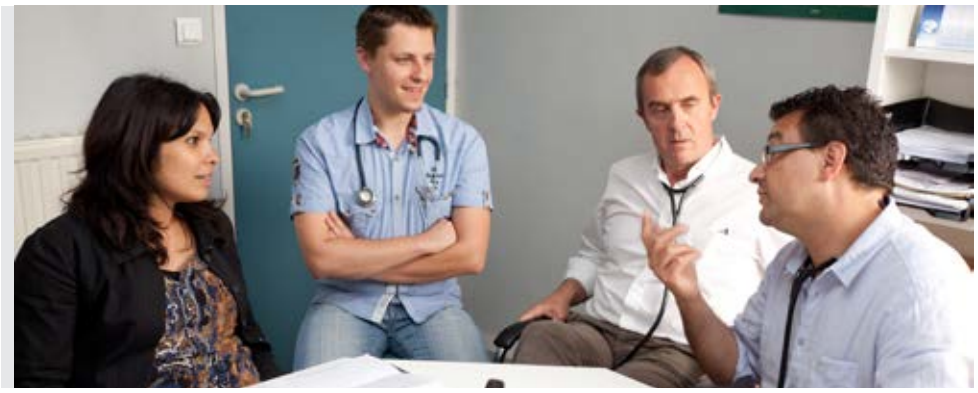
19/MAB/01B

EDITORIAL

Prioritising quality improvement

Primary care QI is a team sport, best played by those making the changes



SPL

In almost every part of our lives we are inundated with information. The working lives of primary care doctors and their managers are no different. In 1964 Bertram Gross, professor of political science at Hunter College in New York, defined the concept of information overload:

> *"Information overload occurs when the amount of input to a system exceeds its processing capacity. Decision makers have fairly limited cognitive processing capacity. Consequently, when information overload occurs, it is likely that a reduction in decision quality will occur."*[1]

The quality of the care we provide is measured, benchmarked, and reported back to us by a multitude of organisations. In England, primary care doctors can compare their patient experience scores with those of the practice down the road through the National GP Patient Survey.[2] They can see how well they are achieving screening targets on the public health websites[3] and compare their prescribing on openprescribing.net.[4]

Commissioning organisations send practices data on referring behaviour, rates of unplanned admissions, or how much their patients use the emergency department. Some aspects of performance can affect practice income through performance related pay,[5] including targets for treatment and follow-up of patients with long term conditions. Regulators use much of this information to guide judgments of services provided.[6]

High quality care develops when an organisational culture promotes curiosity and continuous small cycles of change

Where to start?

With so many possible areas where improvements might be made, it can feel like an impossible task to choose which should take priority.

Improvement often needs several iterative cycles before solutions that work emerge. Sustained improvement takes time and effort, and it is easy to get demoralised if practices or individuals take on too many projects and can't follow them through. It is tempting to prioritise the areas that affect practice income or please regulators rather than projects that matter more to patients and staff.

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Incremental changes

High quality care develops when an organisational culture promotes curiosity, experimentation, and continuous small cycles of change, particularly when changes are designed and driven by the people delivering care, in full collaboration with patients.[7]

Quality improvement is a team sport and is played best when owned by those making the improvements. Projects work best when priorities are set locally unless external benchmarking data show problems with patient safety or quality of care or practice viability is being affected by poor performance in financially driven targets.

Primary care doctors have an important role in quality improvement. They need to be aware of practice performance data and find ways to present it to the practice team and patients in a meaningful way—for example, by taking into account variations in practice demographics and list turnover.

The increase in primary care workload without a matched increase in funding limits the time available for practice development and improvement.[8] Although there has been some attempt to rectify this, until the effects are felt at the frontline, practices must prioritise improvements that focus on working more effectively and efficiently.

This is in line with the NHS sustainable improvement programme Time for Care.[9] Feedback from participants of the programme indicates that it has improved job satisfaction and teamwork and embedded basic quality improvement methods that practices can apply to other aspects of care such as patient outcomes and access.

Improvement won't happen unless people take action. The importance of "starting with why" has been recognised in many workplace environments,[10] and healthcare delivery and improvement is no different. If people working in a practice have a strong sense of purpose and know why they do what they do, they will notice when current performance isn't delivering their aspirations. This can generate improvement priorities that resonate with the values, vision, and purpose of the team and the organisation.

Using these priorities to create broad themes over time creates a coherent and meaningful improvement plan that everyone understands and can work towards.

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EDITORIAL

Reporting research findings to participants

Dissemination must become the default expectation for all research

The results of clinical trials should be disseminated to those who took part in them. It is a basic courtesy, and an ethical imperative. The World Medical Association's Declaration of Helsinki insists that "all medical research subjects should be given the option of being informed about the general outcome and results of the study."[1]

Research subjects contribute to the greater good and expose themselves to risk of harm. They have a right to know the outcome of the research. This is especially important for participants with a direct interest in the findings, for whom knowledge can be power.

Reporting back to participants is part of the discipline of transparency that keeps researchers honest and accountable. It fits with the broader responsibility of scientists to communicate their work and foster public understanding. It is part of making patient and public involvement a core strand of health research. It is consistent with a welcome focus on lay summaries, shortly to become mandatory as part of the EU clinical trials directive.[2]

Reporting back to participants is part of the discipline of transparency that keeps researchers honest and accountable

No incentive

In that context, the results of a recent survey of trial authors by Schroter and colleagues are disappointing.[3] Fewer than half the respondents had reported (or planned to report) their clinical trial findings to participants. The proportion was similar when it came to sharing results with relevant patient communities. How can we explain this?

One clear answer is that researchers are under very little pressure to disseminate results to patients and participants. Funders, regulators, universities, and ethics committees rarely required (or funded) such dissemination.

In a world where transparency is a widely accepted priority, this is at first surprising. Publication is often taken as a proxy for transparency. But while results might be in the public domain it doesn't follow that people know about them, can find them, have access to them, or make sense of them.

No excuse

In the absence of pressure for action, justifications for inaction crowd in. When asked about barriers to dissemination, some respondents to the survey said that people would not be interested in trial results, would not understand them, and might indeed misunderstand them.

Similar objections were once made about patients accessing their medical records. These responses reveal untested assumptions and border on the patronising. As with access to medical records, a lack of demand from patients is interpreted as a lack of interest, when it is just as plausibly an indicator that people "don't know what they don't know."

Complex clinical research can be difficult to explain. The results of a trial can have a substantial emotional impact, dashing personal hopes or unwittingly giving false hope. In the wider context, results could be misrepresented, especially in social media. All these are legitimate concerns, but they are not reasons for avoiding communication but rather for doing it well.

Getting it done

Doing it well, however, takes time, will, skill, and resources. It requires researchers to devote thought and energy to targeting individuals and organisations and to tailoring their messages to meet people's varying information needs. Just because something is the right thing to do is no guarantee that it will get done.

Guidance could help, perhaps produced by respected research organisations such as the UK's National Institute for Health Research. But guidance will achieve little without a more fundamental change in culture.

Communicating research outcomes to participants and relevant patient and carer communities must be the default expectation, built into the design, budgeting, and governance of clinical trials, along with other strands of patient and public involvement.

The BMJ set an excellent example at the start of 2019 by requiring authors of research papers to describe plans for disseminating their findings to participants and other relevant communities, or to declare that they have none.

It is time for funders, regulators, institutions, ethics committees, and other journals to follow suit. They should insist that researchers disseminate results to participants and patient communities, and be prepared to consider sanctions for failure to comply.

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THE MAIN PARTIES' PLEDGES ON HEALTH

CONSERVATIVE PARTY

FUNDING

- Increase NHS funding by £34bn a year by the end of the parliament (£20.5bn in real terms, a 3.4% rise)
- £1bn extra a year for social care every year
- Build and fund 40 new hospitals over the next 10 years and upgrade 20 hospitals
- £74m over three years for extra capacity in community care settings for people with learning disabilities and autism
- £25m (pledged in August 2019) for hospice care

STAFFING

- Recruit and retain 6000 more GPs, 6000 more primary care professionals (in addition to 7500 extra nurse associates and 20 000 primary care professionals announced), and 50 000 more nurses
- Reinstate nursing bursaries
- Hold an urgent review to solve the "taper" problem in doctors' pensions
- End freedom of movement when UK leaves the EU. Create a new "NHS visa" exclusively for skilled overseas staff who apply to work in the NHS

ACCESS

- Boost early cancer diagnosis across 78 hospital trusts
- Create 50 million extra general practice appointments a year (increase of more than 15%) and shorten GP waiting times
- Make car parking free for people in greatest need, such as disabled people, frequent users of outpatient clinics, parents of sick children, and staff on night shifts
- Clamp down on "health tourism" and increase the NHS surcharge paid by patients from overseas

LABOUR PARTY

- Increase NHS budget by an average 4.3% a year (£26bn increase by 2024)
- Provide an extra £1.6bn a year to ensure that access to mental health treatment matches that for physical health conditions
- £2bn to modernise hospitals and end out-of-area placements
- Return NHS England's capital budget to the international average (£15bn more by 2024)
- £1bn in public health
- More funding for services close to patients' homes

- Expand GP training places from 3500 to 5000 a year by 2023-24 to create 27 million more appointments
- Put Agenda for Change terms and conditions into law alongside safe staffing limits for all staff
- Reintroduce nurse training bursary
- Recruit 4500 more health visitors and school nurses
- Review NHS staff tax and pension changes
- If UK leaves the EU, protect rights of free movement

- Abolish prescription charges in England
- Make basic dentistry free
- Make hospital parking free
- Establish a generic drug company. If fair prices are rejected for patented drugs, use Patents Act provisions, compulsory licences, and research exemptions to secure access to generic versions. Aim to increase number of pharmaceutical jobs in UK Ensure rewards match needs
- Introduce mandatory standards for NHS inpatient food

LIBERAL DEMOCRATS

- Raise £7bn a year from a 1p in the pound rise in income tax for social care, staffing, and mental health and prevention
- £10bn capital investment in equipment and buildings
- Reinstate funding that was cut from public health budgets
- Increase spending on climate and environmental objectives to at least 5%
- Develop a progressive Health and Care Tax
- Introduce a statutory, independent budget monitoring body for health and care

- End GP shortfall by 2025 by training more GPs and making more use of other healthcare staff and digital appointments
- Produce a workforce strategy
- Seek to attract staff from EU by making registration process more flexible and accessible
- Incentivise healthcare staff to work in areas of shortage
- Implement recommendations of Roger Kline's report into lack of diversity in NHS senior management and commission a strategic analysis of racial discrimination in NHS

- Introduce maximum waiting time standards on mental healthcare, starting with services for children, eating disorders, and severe and enduring conditions
- Increase access to clinically effective talking therapies
- Free prescriptions for people with chronic mental health conditions
- Decriminalise abortion and legislate for access in Northern Ireland. Free abortion services
- Ensure that HIV pre-exposure prophylaxis is fully available

The manifestos of the Conservatives, Labour, and the Liberal Democrats contain many promises aimed at improving health and social care. Here are the highlights

PUBLIC HEALTH

- Invest in preventing disease
- Uphold commitment to extend healthy life expectancy by five years by 2035
- Continue to promote uptake of vaccines through national vaccination strategy
- Tackle gambling addiction and reduce drug related deaths
- Extend social prescribing
- Overhaul NHS screening and use more new technology and mobile screening services
- Improve hospital food alongside a wider national food strategy

SOCIAL CARE

- Seek a cross party consensus to bring forward necessary proposals, and legislation for long term reform
- Guarantee that no one needing care has to sell their home to pay for it
- Extend the entitlement to leave for unpaid carers to one week

CLIMATE

- Lead the global fight against climate change by delivering net zero greenhouse gas emissions by 2050
- First budget will prioritise the environment: investing in R&D; decarbonisation schemes; new £4bn flood defences; electric vehicle infrastructure; and clean energy
- Use £1bn Ayrton Fund to develop affordable and accessible clean energy
- Support clean transport
- Set strict new laws on air quality

OTHER PLEDGES

- Keep the price the NHS pays for drugs and the services the NHS provides off the table when negotiating trade deals
- Enshrine the NHS long term plan in law
- Legislate so that patients with mental health conditions such as anxiety and depression have greater control over their treatment
- Make it easier for people with learning disabilities and autism to be discharged from hospital and improve how they are treated in law

- Reduce health inequalities through a comprehensive children's health strategy
- Legislate to enshrine health aims in all government policies
- Invest in children's oral health, tackle childhood obesity, and extend sugar tax to milk drinks
- Ban fast food outlets near schools and enforce stricter rules on advertising of junk food and on salt levels in food
- Plan to regain WHO measles-free status
- Fully fund sexual health services and PrEP roll out

- Build a comprehensive national care service for England
- Provide free personal care for older people
- More than double the number of people receiving publicly funded care packages
- Cap personal contributions to care costs
- Develop eligibility criteria that ensure the service works for everyone
- End 15 minute care visits
- Increase the Carer's Allowance for unpaid full-time carers

- Develop recommendations of "30 by 2030" report to put UK on track for a net zero carbon energy system within the 2030s
- Deliver nearly 90% of electricity and 50% of heat from low carbon and renewable sources by 2030
- Launch national transformation fund of £400bn
- Target research to tackle challenges such as the climate crisis and antibiotic resistance
- Ensure NHS becomes net zero carbon with an "NHS Forest" of a million trees, more efficient heating and insulation systems

- Ensure all parts of NHS are fully excluded and protected from any international trade deals
- End and reverse privatisation in the NHS by repealing the 2012 Health and Social Care Act and ending requirements to put services out to tender
- Improve stroke, heart disease, and cancer survival rates
- Call a moratorium on bed cuts
- Progress prescription of medical cannabis

- Publish a wellbeing strategy to put better health at heart of all policies
- Keep public health within local government
- Legislate for NICE approved interventions to be available within three months
- Restrict marketing of junk food to children. Close loopholes in the soft drinks industry levy
- Introduce levy on tobacco and gambling companies to help fund services
- Introduce minimum unit pricing for alcohol in England

- Establish cross party convention to agree on sustainable, long term funding of a joined-up health and social care system
- Create new professional body for care workers
- Professional regulation of care home managers
- Provide more choice at the end of life and move towards free social care at end of life
- Raise the amount people can earn before losing Carer's Allowance

- Set a new legally binding target to reduce net greenhouse gas emissions to zero by 2045 at the latest
- Implement the UK's G7 pledge to end fossil fuel subsidies by 2025
- Establish a Department for Climate Change and Natural Resources, appoint a cabinet level chief secretary for sustainability in the Treasury to coordinate government action
- Create a statutory duty on all local authorities to produce a zero carbon strategy

- Stop Brexit and prevent more access by US corporations to the NHS and the drug market
- Support proposed changes to the Health and Social Care Act
- Move towards single budgets for health and social care
- Implement recommendations of the Wessely review of the Mental Health Act
- Review discriminatory practices aimed solely at LGBT+ people
- Introduce a legal, regulated market for cannabis

Gareth Iacobucci, *The BMJ*

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ELECTION

SURREAL, UNLIKELY, AND CURIOUS: THE VOTERS' CHOICE ON HEALTH

Andy Cowper examines the Conservative, Labour, and Liberal Democrat manifestos for the 2019 general election

CONSERVATIVES

The Tory manifesto has an air of the surreal, and it's hard to know where to even start with such a blatant cocktail of the misleading and the untrue: it promises "40 new hospitals, while delivering 50 000 more nurses and 6000 more doctors."

These pledges imply that there is a magical warehouse of doctors, nurses, and GP appointments. The reality is that the NHS has a longstanding workforce crisis, and solving it will be expensive, take years, and probably require significant immigration.

It is clear that just six hospitals have actually been promised money for significant redevelopment by 2025, with another 38 pledged "seed funding" sums of money to plan for redevelopment. Yet Boris Johnson has repeatedly claimed "40 new hospitals," though the costings document gets the numbers correct, referring to "20 hospital upgrades" rather than "new hospitals."

The costings document also makes a pledge to "reduce the incidence of 'health tourism.'" The notion of the NHS suffering from too much health tourism is one of the classic health policy zombies: it has been killed many times yet somehow does not die. The costings document goes on to claim that enforcement of limits on health tourism, an extended Cancer Drugs Fund, and the cheaper "NHS visa" to attract staff from overseas will all be funded from existing budget allocations. But it does not say what will be cut to pay for all of these.

There is also no clear plan on social care, only a note that the current allocation will be maintained, alongside a commitment to build a cross party consensus. That doesn't seem like a plan.

The manifesto does have some worthwhile content, with repeated references to public health, early diagnosis, and prevention. There is a commitment to reduce health inequalities (although no detail on how), and a pledge to give mental health parity of priority with physical health.

LABOUR

Labour's manifesto promises to "give the NHS the funding it needs, end privatisation, and never let our health service be up for grabs in any trade negotiation."

It also commits to free prescriptions for all, free basic dentistry, and free personal care for older people. There is a promise for public sector "year-on-year above-inflation pay rises, starting with a 5% increase." On NHS funding, Labour promises to "increase expenditure across the health sector by an average 4.3% a year." There are also sensible words on capital and infrastructure, and pledges on moving support to community settings and on a net zero carbon NHS policy—and even an NHS Forest.

The party's swing to the left is clear in its pledges on the private sector. The manifesto gives plenty of space to claims over NHS privatisation, with the striking statement that "every penny spent on privatisation and outsourcing is a penny less spent on patient care." But this isn't the reality for an NHS patient being treated at the NHS tariff price in a private hospital because of long waiting times for NHS elective care.

Labour has promised to fund its spending commitments of £83bn by raising income tax on people earning above £80 000 and corporation tax, a new tax on financial transactions, and a windfall levy on polluting companies. The independent Institute for Fiscal Studies says "it is unlikely that one could raise the sums suggested by Labour from the tax policies they set out."

LIBERAL DEMOCRATS

The Liberal Democrats propose that part of their spending plans will come from a "Remain Bonus" of £50bn in economic growth that would result from their pledge to not leave the EU.

They plan to fund spending increases from taxation, borrowing more only for investment projects, and they want to increase the basic rate of income tax by a penny. They would invest £10bn of their capital fund in equipment and buildings, and there are also pledges to train more GPs, improve workforce planning, and ringfence funding for mental health. Hypothecated taxes are a big theme, with their plan for "a dedicated, progressive Health and Care Tax, offset by other tax reductions . . . and set out transparently, on people's payslips." But this seems to sit curiously with a pledge to depoliticise funding decisions by creating "a statutory independent budget monitoring body for health and care, similar to the Office for Budget Responsibility."

The manifesto proposes full integration of health and social care but fails to seriously consider how to fund what is currently means tested social care. The Lib Dems hide behind the magical realist solution of a "cross-party health and social care convention." Previous social care commissions—be they Royal (1999), Dilnot (2011), or Barker (2014)—have not proved brilliantly effective.

In examining the parties' manifestoes, it is worth remembering that the Conservatives have been in government, solely or in coalition, for a decade. A firm judgment of their health policy proposals is inevitable because they are unarguably the creators of the situation in which the NHS and social care are found today: a funding crisis, a workforce crisis, and a performance crisis. As the old quote goes, "They have learnt nothing and forgotten nothing."

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Purdah can't stop doctors from speaking their minds

The public wants to know healthcare professionals' views on policy proposals, says **Ingrid Torjesen**

Some NHS trusts have been accused of overzealously applying the "purdah" rules that aim to ensure the political neutrality of government and public organisations ahead of elections. Some have barred NHS staff from expressing their own personal political views on social media.

Alastair McLellan, editor of the *Health Service Journal*, tweeted that an NHS source had "been told not to 'like' tweets because of purdah." The *Guardian* reported several examples, including the Scottish ambulance service, whose staff had been told that if they mentioned their employer "on your personal social media channels, you cannot get involved in any online activity, debate or discussion which is political in nature."

NHS England's chief executive, Simon Stevens, wrote to NHS managers when the election was announced. "The NHS must act and be seen to act with political impartiality, and its resources must not be used for party political purposes," the letter says, but also, "NHS employees are free to undertake political activism in a personal capacity."

He advised avoiding "proactive media work" and posting on social media about "contentious" issues. "Major publicity campaigns" should be avoided unless time critical, but "ongoing business as usual campaigns . . . can continue as planned."

The Cabinet Office advises that regular statistics and routine factual publications can continue to be issued. But many organisations are not responding to regular media queries, have halted planned health promotion campaigns, and have postponed publication of information that could improve services, including a confidential inquiry into maternal deaths.

Meanwhile the government's announcement that doctors' pension tax will be reimbursed is "a breach of purdah rules to spare [the government] embarrassment for previous inaction," says the former chair of the health select committee, Sarah Wollaston.

Despite Brexit, recent polling found that the NHS is the most important issue for 59% of voters, and 18% say that health policies will determine their vote, so their hearing reactions of NHS staff to proposed policies could be crucial. Indeed, many staff are speaking out, including in a new video for the pressure group Keep Our NHS Public.

Jacky Davis, cofounder and consultant radiologist, told *The BMJ*, "In 2017 a video produced by NHS staff for the election went viral, with about 11 million views, and was credited at Conservative headquarters with having contributed to [Theresa] May's dire results.

"The Conservatives must be very aware of their poor record on the NHS and of the dangers of allowing NHS staff to expose it during the election period."

Personal capacity

Charlotte Harpin, from the legal firm Browne Jacobson, explains, "People who work for the NHS shouldn't give comments or behave in a way that could be interpreted that they are speaking as an official representative of their organisation."

There is nothing wrong with doctors commenting in a personal capacity, but they should think about removing any affiliation information from their social media

There is "nothing wrong" with doctors commenting in a personal capacity, she says, but they should not do it while standing by a sign of the trust that employs them and should think about removing any affiliation information from their social media accounts, she adds. "Ideally, there should be a clear distinction about what they do in their private capacity drawing on their professional role and what they do as a member of the organisation they work for."

"There is overinterpretation at every level on purdah," says Fiona Fox, chief executive of the public relations agency the Science Media Centre, which lobbied the Cabinet Office over researchers who are linked to government organisations being prevented from providing independent comment before the 2017 general election.

Sue Gray, the civil servant in charge of purdah at the time, clarified that purdah principles "are not about restricting commentary from independent sources, for example academics." Fox says the situation is now "much better."

Because of local confusion over purdah rules, clarification for NHS staff "might be helpful," Harpin says. But when *The BMJ* approached NHS England, the Department of Health and Social Care, NHS Employers, the BMA, the Electoral Commission, and the Cabinet Office for such clarification, all declined to comment.

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ELECTION

Will the UK remain a research superpower?

Jacqui Wise listens to the political parties' promises for R&D after next month's election

The UK's three largest political parties made a commitment to increase spending on research and development (R&D) in their election manifestos and at a science hustings at the Royal Society in London last week.

The Royal Society, the Academy of Medical Sciences, the British Academy, and the Royal Academy of Engineering want the next government to ensure investment of 3% of gross domestic product (GDP) in R&D by the end of the coming decade.

The UK currently spends 1.69% of GDP on R&D, placing it 11th among EU countries. A 3% target would match countries such as Germany but is still below the high tech countries Israel and South Korea, which spend 4.55% of GDP. Public investment in R&D in the UK is currently 0.43% of GDP, which the academies want to see raised to 1% to trigger more private investment.

Conservative Stephen Metcalfe, former chair of the science and technology committee, told the hustings that the current Tory government had pledged to reach a total 2.4% of GDP by 2024-25. He said that the party would increase public spending to 0.62% of GDP.

A quick Brexit would encourage companies to do research in the UK
Stephen Metcalfe, Conservative

Public funding is needed where the market is failing to provide
Chi Onwurah, Labour

3% of GDP will remain a fantasy target if we pursue a hard Brexit
Sam Gyimah, Liberal Democrat

Committed to 3% of GDP

Both Labour and the Liberal Democrats are committed to the 3% target. Chi Onwurah, Labour's science and innovation spokeswoman, said a Labour government would raise total R&D spending to 1.85% of GDP in its first two years in office. Labour's manifesto pledges an "innovation nation," with 3% of GDP spent on research and development by 2030. Onwurah said that public funding was needed for research that the market was failing to provide, particularly in public health, such as antibacterial research.

The Liberal Democrats' manifesto said it would achieve the 3% target through an interim 2.4% of GDP by 2027. Sam Gyimah, the party's spokesman for business, energy, and industrial strategy, noted that the 3% target was ambitious and would remain a "fantasy target" if the country pursued a hard Brexit, as companies would leave the UK. "Remaining in the EU is the only way to advance science," he added.

Aisling Burnand, chief executive of the Association of Medical Research Charities, said she was "pleased to see what seems to be a consensus between political parties that more spending is needed . . . But we urge them to have and share clear plans of how they will achieve these increases."

The Royal Society's own manifesto says that, for research to thrive, the Brexit outcome needs to protect people, funding, and collaboration. Venki Ramakrishnan, the society's president, told the hustings that the Brexit process had caused the UK "huge reputational damage" as a destination for researchers and asked how the parties would tackle this.

Gyimah responded that, by revoking article 50 and stopping Brexit, the Liberal Democrats would show that the UK was "open and welcoming" and would continue to attract the best researchers globally.

Metcalfe argued that the Conservatives would get Brexit done quickly and would encourage companies to do research in the UK. He added that the Conservatives would invest £800m over five years to set up an agency to fund high risk, high reward research, such as in artificial intelligence.

Onwurah said Labour would end the "hostile environment" for immigrants that had damaged the UK's reputation and discouraged researchers from working here.

The One Cancer Voice manifesto, written by 20 cancer charities, states that 4800 UK-EU trials took place from 2004 to 2016. It says that researchers must be able to work across borders and calls on the next government to prioritise close relations between the UK and EU on clinical trials.

Onwurah also talked about Labour's manifesto plan for a "green industrial revolution" that would target research and innovation to tackle the climate crisis and other challenges, such as population ageing and antibiotic resistance.

EU funding at risk

The academies warned that, without a Brexit deal, the UK would lose access to Horizon Europe, the almost €100bn EU programme that funds UK research and collaboration around the world. The Conservative manifesto says that the party would seek to retain full membership in any Brexit negotiations.

Burnand welcomed this. "For the UK to remain a science superpower they must seek the closest possible association with the Horizon Europe funding programme," she said.

Beth Thompson, head of UK-EU policy at the Wellcome Trust, warned that regulation is being overlooked: "Collaborating across borders is much easier with shared rules and standards.

"We already have examples of Wellcome funded research being delayed by uncertainties over post-Brexit data protection guarantees. We want to hear how the parties will approach research regulation after Brexit."

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