Consultants to vote on new pay offer

The BMA and the Hospital Consultants and Specialists Association are to put a pay offer to consultants in England after negotiations with the government.

The offer is for a 4.95% investment in pay for this financial year, in addition to the 6% pay rise already awarded for this year. If the offer is accepted the changes will come into force in January but paid retrospectively in April.

The new offer provides “much needed” changes to the structure of the consultants’ pay scale, said the BMA, which will result in fewer points at which pay rises. Consultants will reach the top of the pay scale five years sooner than under the current scheme.

All consultants will receive the 6% increase in 2023-24 offered in July, and most will receive an additional rise of up to 12.8%, depending on their pay point. For example, new consultants will now start on a salary of £99,532, an increase of 12.6% from £88,364 on the 2022-23 salary. The highest paid consultants will receive £131,964 from January, up 10.8% from £119,133.

Rishi Sunak, the prime minister, said, “This is a fair deal for consultants, who will benefit from major reform to their contract. It is fair for taxpayers, because it will not risk our work to tackle inflation, and most importantly it is a good deal for patients.”

The BMA said the changes will benefit women who take time out for caring responsibilities and extend rights for enhanced shared parental leave.

The offer also includes commitments to reform the Doctors’ and Dentists’ Pay Review Body, giving the BMA a say in the selection of its members. The government also agreed to no longer include information on economic performance in its remit letters to the body and to remove references to inflation targets from the DDRB’s terms of reference.

Vishal Sharma, chair of the BMA’s Consultants Committee, said, “The 4.95% investment and much needed changes to the pay scale system come after we successfully persuaded the government to reform the punitive pension taxation laws earlier this year, and we also now have commitments to reforming the pay review process, which has been a key ask throughout our dispute. Only by restoring the independence of this process can we hope to restore consultant pay over the coming years.”

Consultants will be sent details of the offer and will vote on the proposals in December and January. If the offer is accepted there will be no more strike action.

Zosia Kmiotowicz, The BMJ
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The BMA is to ballot its consultant members on the government’s extra 4.95% pay offer and DDRB changes

LATEST ONLINE

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Scrap contracts allowing private firms to “play fast and loose” with GPs, say LMCs

Time limited contracts that allow private companies to run NHS general practices should be scrapped, GP representatives have urged.

The annual conference of England’s local medical committees heard that the recent decision by the US firm Centene (Operose) to sell its network of around 60 GP clinics just two years after acquiring them showed it was time to provide greater stability to practices and patients and to stop using the alternative provider medical services (APMS) contract.

A motion passed by the meeting in London on 23 November called for an end to APMS and for all new and retendered contracts to be operated under a standard general medical service (GMS) contract. In 2022–23 there were 235 APMS providers in England, 4% of practices.

London, where surgeries have been affected by Operose’s withdrawal. “Over half a million patients are left uncertain about their general practice services, and thousands of staff, including GPs, will be wondering about their job security,” she said. “It’s a disgrace that US multinationals should be able to play fast and loose with UK general practice, and it must never be allowed to happen again.”

Cancer
Smear test drive launched as screening rates fall

Women in England are being urged to accept invitations for NHS cervical screening, as figures showed that the proportion of attendees fell to 68.7% in 2022–23 from 69.9% the previous year. The proportion was higher among 50–64 year olds (74.4%) than in 25–49 year olds (65.8%). Kiren Collison, a GP and NHS England’s deputy medical director for primary care, said women who had been unable to attend should not wait for another invitation but should contact their GP surgery for a test.

NHS
Chaotic communication is delaying treatments

The public services research charity Demos called for better communication in the NHS in England after a survey of 2000 staff and public found that over half (55%) had experienced poor communication in the past five years, and one in 10 said their care had been affected by an admin or IT error. Lost referrals, not knowing the right person to contact, and miscommunication about treatment were also common. Demos called for more non-clinical staff to help patients navigate systems, with better IT.

Undefined deaths
Number of decomposed bodies sparks concern

Researchers raised concerns over the rising number of dead people in England and Wales whose bodies had begun to decompose by the time they are discovered—a signal, they said, of “wider societal breakdowns of both formal and informal social support networks.” Undefined deaths rose from 50 in 1979 (0.0086% of all deaths) to 1159 in 2020 (0.19%), they reported in the Journal of the Royal Society of Medicine, noting that this was likely to be a significant underestimate. They urged authorities to make it easier to identify such deaths in routine data so that these can be tracked and issues identified.

Transgender identity
Highest rise in UK is among 16–29 year olds
UK rates of transgender identity have risen fivefold since 2000, from roughly one person in every 70 000 in 2000 to around one in every 13 000 in 2018, found an analysis of anonymised GP records in BMJ Medicine. The largest rise occurred in 16–29 year olds. In 2018 the proportion of people identifying as transgender and coded as such in their medical records had reached roughly one in 600 people aged 16–17 and around one in 800 aged 18–29. Rates were more than twice as high in the most socially and economically deprived areas as in less deprived areas.

LMCs conference
England’s GPs demand a right to vote on contracts

The motion was proposed by Jackie Applebee (left), chair of Tower Hamlets LMC in east London, where surgeries have been affected by Operose’s withdrawal. “Over half a million patients are left uncertain about their general practice services, and thousands of staff, including GPs, will be wondering about their job security,” she said. “It’s a disgrace that US multinationals should be able to play fast and loose with UK general practice, and it must never be allowed to happen again.”

Antibiotics
Use without prescription on rise in Europe and Asia

A third of 8221 people surveyed by the World Health Organization in 14 European and central Asian countries, in regions including the western Balkans, the Caucasus, and central Asia, had consumed antibiotics without a medical prescription in the past 12 months. In some countries over 60% of antibiotics were obtained without medical advice, showed the survey published in the journal Frontiers. The equivalent survey in 2022 had the figure at only 8%. WHO said the findings highlighted a worrying lack of enforcement around antibiotic use and a need for public education.
Diabetes
Faster walking lowers type 2 risk, says research
A walking speed of 4 km an hour or faster is linked to a significantly lower risk of type 2 diabetes, showed a pooled data analysis of 10 studies that lasted 3-11 years and included 508 121 adults from the US, Japan, and the UK, published in the British Journal of Sports Medicine. The researchers said faster walking speed was associated with better cardiorespiratory fitness and muscle strength, which are linked to diabetes risk, and brisk walking is good for weight loss, which helps improve insulin sensitivity.

Sepsis
Deprivation increases risk of dying from infection
People from the most socioeconomically deprived groups in England are almost twice as likely as the least deprived to die from sepsis within 30 days, showed an analysis of 224 361 non-covid sepsis cases from 1 January 2019 to 31 June 2022. Comorbidity and learning disabilities were also associated with an increased mortality risk, found the study published in eClinicalMedicine. Colin Brown, study author, said, “Tackling inequalities is a core part of our public health approach, and a deeper understanding of who serious bacterial infections affect will help us best target interventions to address them.”

Tobacco
WHO highlights tobacco industry marketing tactics
The World Health Organization has launched a “Stop the Lies” campaign, calling for youth groups around the world to “adopt decisions that shield us from the manipulative practices of tobacco and related industries.” Ruediger Krech, WHO director of health promotion, said, “WHO stands with young people globally who have demanded governments protect them against a deadly industry that targets them with new harmful products while outright lying about the health impacts. We call on all countries to safeguard health policies from this deadly industry by not letting them have a seat at the policy making table.”

Environmental pollution caused by plastics in cigarette butts and packaging costs an estimated $26bn (£20.6bn) a year or $186bn every 10 years in waste management and marine ecosystem damage worldwide, adjusted for inflation [Tobacco Control]

WHY ARE YOU SHOUTING?
It’s good news! Scientists at the University of California, Davis, think they’ve found why some people develop a headache after drinking red wine.

SMOKING
WHY DOES IT HURT?
Don’t whine. In a study published in the journal Scientific Reports the researchers said they think that a flavanol found naturally in red wines can interfere with the proper metabolism of alcohol and lead to a headache.

BUT WHAT UNCORKS THE HEADACHE?
As a result, the researchers said, you accumulate acetaldehyde—a toxin known to cause facial flushing, headache, and nausea. Disulfiram, a treatment for alcohol misuse that blocks the enzyme that breaks down acetaldehyde, causes similar symptoms.

SO, VINO’S OFF THE MENU?
Not necessarily. The researchers said that quercetin levels vary, depending on how the grapes are made and how much sunlight the grapes have had. Also, they said that red wine contains much higher levels of quercetin than white wine or other alcoholic beverages. Everything happens for a riesling, I guess.

CASE CLOSED
Not entirely. The researchers still don’t know if the enzymes in people who get red wine headaches are more easily inhibited by quercetin or if they’re just more easily affected by the build-up of the toxin acetaldehyde.
GPs should introduce waiting lists, says BMA

GPs need to consider creating waiting lists for patients to manage their workload, the BMA has said. Speaking at the annual conference of England’s local medical committee (LMC) representatives, Katie Bramall-Stainer, chair of the BMA’s GPs committee, urged GPs to adjust patients’ expectations about what GPs could deliver with the resources they had.

“Think about creating waiting lists,” she said. “Think how they can provide patient choice, how that can embed continuity of care, how that can provide variety to a challenging day.”

Bramall-Stainer described the “hamster wheel” of demand on health services and the need to match activity to capacity. “Trusts know the speed at which to run their own hamster wheel—do you?” she asked. “They provide what they can with what they have in the time they’ve got—do you? You’ve got to control the speed of your own hamster wheel. And that means providing a safe number of appointments that you can with the staff that you have.”

The conference passed a motion on capping GP workload that called for systems that had passed safe working limits to send patients elsewhere. The motion, proposed by Rachel Ali, chair of Devon LMC, also demanded that safe working limits be considered a “red line” in contract negotiations.

Ali also called for the introduction of waiting lists for general practice.

“We’re a finite resource and we need to be looking after our colleagues and ourselves,” she told the audience. “For us to reach a limit and say this is as much as we can do, we have to be able to divert urgent patients elsewhere.

“We need to be offering waiting lists for our routine patients,” she said.

“And we need to know that, when someone calls, when we’re full, they are going to be triaged, and that triage is going to make sure that only the urgent people go to the overflow and that the routine people are told to call us back and go on a routine waiting list.”

Tim Horlock, from Somerset LMC, also spoke in favour of waiting lists.

Debate on associates is affecting their health and wellbeing, NHSE warns

NHS England has asked the BMA to bring forward a meeting arranged for later this month to discuss medical associate professionals (MAPs), including physician and anaesthesia associates. It warned that the public discourse on associates was “impacting relations” between BMA members and their MAP colleagues.

Earlier this month the BMA called for the recruitment of MAPs to be paused immediately. It also opposed the GMC regulating associates, which is due to start by the end of 2024. In an open letter sent to the BMA on 22 November, Navina Evans, NHS England’s chief officer for workforce, training, and education, and Stephen Powis, its national medical director, suggested meeting with the union sooner than arranged to discuss the concerns.

The letter said, “This continuing public discourse around MAPs is impacting relations between your members and their MAP colleagues, the health and wellbeing of MAPs already working in the NHS, and potentially the confidence of patients. We are keen to work together to address these issues as soon as possible in the interests of patients.”

The BMA did not say whether it agreed to bring forward the meeting. Latifa Patel, chair of the BMA representative body, reiterated it was important that MAPs’ responsibilities and scope of work were clearly defined to ensure safe care, avoid any potential confusion for patients, and ensure MAPs were regulated appropriately.

She added, “We are aware that some discussions on social media are negatively impacting some associates and their colleagues. All individuals working in the NHS should be treated with dignity and respect, and we will play our part in promoting professionalism, respect, and courtesy within clinical teams.”

Speaking on 23 November at a Westminster Health Forum event, Tim Aldrich, the GMC’s assistant director of regulatory reform, confirmed it would begin regulating associates next December and it would be clear on the register whether someone was a doctor or a MAP.

At the same event, Sarah Massey, president of the Association of Anaesthesia Associates, explained why she thought the GMC was the right regulator. “It makes sense that I hold and I am held to those same values as the colleagues that I work closest with and report to,” she said.

“End plans to limit family visas for health workers”

NHS and social care leaders have called for the government to abandon plans to restrict the number of family members that overseas health and social care workers can bring with them to the UK, which they said would be “ruinous” for services.

The Cavendish Coalition, which represents social care and health employers, trade unions, and educators, said services would not function with a reduced overseas workforce, which in England accounts for 18% of NHS staff and 16% in adult social care.

The coalition has repeated concern expressed in a September letter to Rishi Sunak, the prime minister, that “assuming international health and social care workers would come to the UK without their dependants would be ruinous to our services and the staffing plans you ask us to have.” It warned of detrimental effects on existing staff if the family visa process was disrupted.

The latest expression of concern was in response to proposals by
immigration minister Robert Jenrick to restrict to one the number of relatives international workers could bring to the UK, although relatives could be banned completely. The number of health and social care workers recruited from abroad could also be capped and the minimum salary they must be paid increased, although plans are yet to be confirmed.

Danny Mortimer, co-chair of the Cavendish Coalition and chief executive of NHS Employers, said, “As a country we must do everything we can to make ourselves a more, not less, attractive destination for employment, especially in a continued vacancy crisis across our sector and in the absence of long term plans for social care services. ‘With global demand for health workers set to rise to 80 million by 2030, we would urge the government to halt these senseless proposals and protect recruitment in social care and health.’

Net migration to the UK hit a record high of 745 000 last year. The Times reported that 282 742 health and social care visas were granted in the year to June, up 18.2% on the previous year. More than 151 774 visas were issued to their dependants, it reported.

of the motion. “We need to be clear that too many of us are forced—by falling GP numbers and the current contract, which is uncapped—to provide unsafe levels of consultations on a regular basis,” he said. “I don’t think there should be any shame in talking about safety or workload capping,” he added. “Indeed, talking about safety is one of our duties as doctors, so we need to admit that the current situation is widely unsafe.”

Zosia Kmietowicz, The BMJ
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PM was bamboozled and confused over science

On 20 November Patrick Vallance, the government’s chief scientific adviser during the pandemic, was asked about the then prime minister Boris Johnson’s understanding of scientific concepts. The inquiry was presented with several extracts from Vallance’s personal notebook. One diary entry from May 2020 described Johnson as being “clearly bamboozled” by discussions about modelling on schools. Another extract from the same month said Johnson was “confused” about the different types of covid tests. And in June 2020 Vallance wrote, “Watching PM get his head around stats is awful. He finds relative and absolute risk almost impossible to understand.” Vallance told the inquiry, “I think he’d be the first to admit [science] wasn’t his forte and that he did struggle with some of the concepts and we did need to repeat them often.”

Sunak spoke of controlling “scientists, not the virus”

The inquiry pressed Vallance on extracts from his diaries that indicated that advice from the Scientific Advisory Group for Emergencies (SAGE) was sidelined by senior government ministers, who suggested that the scientists needed to be handled in some way.

One extract said, “In economics meeting earlier in the day they didn’t realise [chief medical officer Chris Whitty] was there and [the chancellor] said, ‘It is all about handling the scientists, not handling the virus.’” “Giving evidence, Vallance said, “It definitely is the case that there were times when, because we were giving unpalatable evidence and advice, people would rather not hear it.”

Vallance also revealed that he and Whitty did not know about the then chancellor Rishi Sunak’s controversial “Eat out to help out” scheme until it was announced publicly. “Our advice would have been very clear on that,” Vallance said, pointing out that the policy “completely reversed” all previous public health advice given during the pandemic.

Yet in his witness statement Sunak had said he did “not recall any concerns about the scheme being expressed during ministerial discussions, including those with the CMO and CSA.”

Advisers diverged but agreed that first lockdown was too late

In his diaries Vallance branded Whitty a “delayer” in the context of the CMO’s reluctance to move early to impose lockdowns and other non-pharmaceutical interventions because of the indirect harms that may be caused, such as loneliness, depression, and poverty.

“We went a bit too late on the first wave,” said Vallance. “I was more on the side of we need to move on this.”

In his evidence Whitty acknowledged he was concerned about the effect of lockdowns and school closures and of the balance between going too early and going too late. But he said overall there were “extremely small” differences between him and Vallance. “My view is, with the benefit of hindsight, we went a bit too late on the first wave,” Whitty said, but he added that the government had “no good options” at the time.

Whitty thought pandemic planning was “woefully deficient,” even for flu

During his evidence Whitty said that, after examining the UK’s pandemic plans drawn up before covid-19, he believed they would have been “woefully deficient” even for a flu pandemic.

He said it was clear in early 2020 that the plan was not going to be particularly helpful, as it was based on the 2009 H1N1 flu pandemic, which had very low mortality.

Gareth Iacobucci, The BMJ
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NEWS ANALYSIS

What next for “wonder drug” Kaftrio?

NHS England has pledged that children aged over 2 who have cystic fibrosis will have treatment for life with the groundbreaking drug, but NICE says it’s not cost effective—leaving parents distressed, reports Jacqui Wise

What is Kaftrio?
The management of cystic fibrosis has been transformed over the past few years by the advent of treatments designed to correct the malfunctioning protein made by the cystic fibrosis transmembrane conductance regulator (CFTR) gene.

Kaftrio, the latest of these CFTR modulator treatments, consists of a triple treatment combination of ivacaftor, tezacaftor, and elixacaftor. It’s a long term treatment for patients with cystic fibrosis who have at least one F508del mutation in the CFTR gene, around 90% of people with the condition.

In 2019, after a lengthy battle over cost, an agreement was reached between NHS England and the drug company Vertex to make two earlier CFTR modulator treatments, Orkambi (lumacaftor-ivacaftor) and Symkevi (ivacaftor-tezacaftor), available on the NHS. As part of the interim access agreement NHS England, NICE, the UK Cystic Fibrosis Trust, and Vertex would collect and share real world data over four years to help resolve uncertainties in the evidence base. In 2020 this agreement was updated to include Kaftrio.

The NHS described Kaftrio as a “miracle” treatment in January 2022. In the UK around 10600 people have CF, and data from 2021 showed that 72% were taking a CFTR modulator, almost three quarters of them taking Kaftrio.

Kaftrio was initially licensed for patients aged 12 and over, but the Medicines and Healthcare Products Regulatory Agency extended the licence to 6-11 year olds in 2022 and recently (15 November) to children aged 2-5.

What has NICE said?
NICE’s draft evaluation of Orkambi, Symkevi, and Kaftrio concluded that “there is a large and robust evidence base for the acute benefits of CFTR modulators.” Clinical trial evidence shows that Kaftrio improves lung function, growth, and weight gain and reduces the number of lung infections more than standard treatment. Clinical benefits are also seen with Orkambi and Symkevi, but the improvements are smaller than with Kaftrio.

The price the NHS pays for these drugs is confidential, but NICE said the incremental cost effectiveness ratios “were all substantially above £30 000 per QALY [quality adjusted life year] gained.” It added, “Even when considering the condition’s severity and its effectiveness on quality and length of life, the most likely cost effectiveness estimates are above the range that NICE considers an acceptable use of resources. So they are not recommended.”

However, the committee did say it was likely that some benefits of treatments were not captured in the economic modelling, such as improved glycaemic control and reductions in CF related diabetes. It also noted the large emotional and financial impact of CF on caregivers. NICE has emphasised that the final decision on CFTR drugs is yet to be made and that patients taking any of the drugs when the final guidance is published would be able to keep taking them regardless of the outcome.

What effect has Kaftrio had?
Patient experts on the NICE committee told NICE about the drugs giving them more options, including in education and employment, and enabling parents and carers to return to work. They said it was “difficult and distressing to think back to a world before CFTR modulators, having experienced their transformative effects.”

The MHRA’s decision to extend the licence for Kaftrio to 2-5 year olds was “very significant and hugely welcome,” said Jane Davies, professor of paediatric respirology and experimental medicine at the National Heart and Lung Institute, Imperial College London.

A baby born with CF has healthy lungs at birth, but mucus accumulation, airway infections, and inflammation occur early and lead to lung damage, which can become irreversible. Bacterial infections are also common in people with CF and add to the burden of treatment.

Davies told The BMJ, “It seems logical that if we could restore the function of the defective CFTR protein before all of this has happened, we give that child a much greater chance of keeping the lungs healthy. Children taking these drugs will have fewer flare-ups—acute deteriorations requiring hospital admission and courses of intravenous antibiotics.”

CF also affects the pancreas, and a significant proportion of younger children starting CFTR modulator drugs can stop taking

THE NHS described Kaftrio as a “miracle” treatment in January 2022. In the UK 10600 people have CF, and data from 2021 showed that 72% were taking a CFTR modulator, almost three quarters of them taking Kaftrio.
a replacement enzyme formulation needed to help digest food, said Davies. She added, “Studies in adolescents and adults suggest that we may also see long term benefits in the other function of the pancreas—insulin production—with a reduction in CF related diabetes. Intuitively, this seems more likely the earlier the drugs are started.”

**What happens now?**

The draft NICE guidance closed for comments on 24 November. A second evaluation committee meeting is taking place on 14 December. In the meantime NHS England has said that any 2-5 year olds can be started on Kaftrio while the NICE review is ongoing and can be given long term access to the drug.

However, for families with children aged under 2 NICE’s draft decision has been deeply upsetting. Davies said, “How would you feel, knowing that the optimism you’ve been clinging onto since your baby’s diagnosis was going to be snatched away? CF is an awful diagnosis to receive, and for most families the hope of these drugs is what’s kept them going.”

NICE has confirmed that Kaftrio is of benefit to patients, but the problem is its high cost. The list price for a 56 tablet pack is £8346, which amounts to annual costs of £100 000 to around £160 000, depending on dosing.

Kevin Southern, professor of child health at the University of Liverpool and chair of the UK Cystic Fibrosis Medical Association, told The BMJ, “Future iterations will probably improve the costing threshold, but it is unlikely that it will come down to a level that is ‘acceptable’ to NICE.”

The current contract with Vertex expires next summer, and NHS England, on behalf of the UK, will start negotiating a new one shortly. However, the previous negotiations dragged on for years before an agreement was reached.

Davies said she hoped that NICE and Vertex would pursue a prompt solution, as “parents are really fearful for the health of their children—they feel like pawns in the negotiation process.”

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**For most families the hope of these drugs is what’s kept them going**

**Jane Davies**

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**Chancellor accused of “deprioritising health” in his autumn statement**

Directors of public health have urged ministers to do more to improve health in people of working age, warning that “punitive” moves to end people’s access to benefits could “do more harm than good.”

The chancellor, Jeremy Hunt, announced a clampdown on benefits as part of his autumn financial statement to the House of Commons on 22 November, which some analysts said “neglected the gravity” of the crisis facing health and care services.

Hunt said that claimants who had still not found employment after seeking a job for 18 months would have to take part in a mandatory work placement “to increase their skills and improve their employability,” He said that, for those who chose not to engage with the work search process for six months, “we will close their case and stop their benefits.”

Hunt was expanding on the “back to work plan” announced earlier this month, intended to help people get back to and remain in work, in a bid to tackle the rising numbers of people unemployed because of long term sickness or disability. He announced funding of £1.3bn over the next five years to help people with health conditions find jobs, with a further £1.3bn to help people who had been unemployed for over a year.

The Association of Directors of Public Health welcomed some “back to work” measures but said that further steps were needed to encourage businesses to invest in workplace health and wellbeing. Ruth Tennant, an association board member, said that earlier action was needed to tackle preventable long term health conditions, to help people with physical and mental health conditions to thrive at work, and ensure coordinated support for people to take steps back into the labour force.

“We need to understand and address the specific barriers faced by those most affected by work limiting health conditions and make sure initiatives target these groups,” she said. “This needs a bold coalition across government, businesses, and communities to address the barriers to work and to build healthy workplaces.”

**HUNT confirmed an increase in the national living wage, from £10.42 to £11.44 an hour from April next year**

Leading health analysts termed the autumn statement a “missed opportunity” to get the NHS back on track after the effects of staff strikes on patient care and budgets.

Layla McCay, the NHS Confederation’s director of policy, said, “Independent experts have said that the costs so far stand at £1.7bn, yet only £800m has been allocated and mainly by raiding budgets elsewhere, which will cause long term harm to the NHS’s ability to transform its services.”

Philip Banfield, BMA council chair, said that in the light of current waiting lists it was “incomprehensible” that Hunt had not offered any support for the NHS. He accused the chancellor of “deprioritising health” and failing to act to retain doctors.

“There’s nothing to support the NHS with the squeeze to budgets brought on by inflation, nor anything to reverse a decade of public health cuts,” said Banfield. “On the one hand Mr Hunt talks about productivity, but on the other the government refuses to provide the investment in buildings and equipment needed for staff to have the tools they need to do their jobs properly in modern and safe workplaces.”

Hunt confirmed an increase in the national living wage, from £10.42 to £11.44 an hour from April next year. This should benefit a large proportion of social care staff, but experts warned that providers could struggle to pay wages and that more could go out of business without additional funding, including general practices.

Hunt said the main employee national insurance rate would fall by two percentage points, from 12% to 10%, from 6 January.

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Matthew Limb, London

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Egyptian Red Crescent Society employees and volunteers organise humanitarian aid, including medical supplies, food, and water, bound for Palestinians in Gaza, at a warehouse in the city of Arish, Sinai, last week.

The medical supplies include chlorine tablets that can purify drinking water and surgery kits that are used to treat people with wounds sustained in conflict. The kits can be used to treat between 1000 and 5000 people, depending on the severity of their injuries.

More than 5500 Palestinians and 1400 Israelis have been killed, according to the Israel Defense Forces and Palestinian health ministry, after an attack by Hamas militants on Israel on 7 October and the retaliatory Israeli operations in the Palestinian territories of Gaza and the West Bank.

Cite this as: BMJ 2023;383: p2799
The state of care in England’s maternity services

Time for a fresh approach to regulation and improvement

The latest Care Quality Commission (CQC) report on the state of care in England is far from an encouraging read. Although the healthcare system is under serious strain, maternity services are among the areas identified as especially challenged.

The cybernetic model of regulation offers a potentially useful way of understanding where effort needs to be directed. In this model, regulation comprises three interlinked elements: standard setting, monitoring, and mechanisms to secure improvement; absence of (or flaws in) any of the three elements makes failure more likely. Standard setting and monitoring, though imperfect, are the stronger elements of England’s current health and social care regulatory system. But the third component—making improvement—is weaker.

The CQC has wide ranging powers of enforcement under civil or criminal law where needed, but responsibility for improving challenged organisations lies elsewhere, and evidence for the effectiveness of improvement mechanisms remains limited.

**Poor evaluation**

Maternity services enter NHS England’s maternity safety support programme if the CQC rates them as “requires improvement” or “inadequate” in the “well led” or “safe” inspection domains. Typically, the support includes improvement advisers providing mentoring, advice, guidance, and promoting quality improvement methods. However, no evaluation of the programme’s effectiveness has been published. Some trusts have been in the programme for several years, and some trusts that exited the programme have re-entered.

Evidence based strategies for improving culture, including professionalism, respectful communication, and anti-racist behaviours, are needed

Of course, the maternity support programme is not the only improvement effort targeting maternity services. Recent years have seen no shortage of recommendations and initiatives seeking to stimulate, incentivise, advise, or support services to get better. The large volume of initiatives and recommendations, and the range of bodies issuing them, is itself a problem. “Priority thickets” may result, where units become overwhelmed, distracted, and confused, paralysing their ability to respond and often lacking the resource and expertise to convert recommendations into effective local solutions.

Many existing improvement efforts are not evidence based, do not include maternity service users or staff in their design, do not align with human factors and ergonomics strategies, lack support for implementation, and are uncosted. Perhaps most damningly, few are formally evaluated, so the evidence base for supporting improvement remains seriously underdeveloped.

A further threat to the effective functioning of the cybernetic model of regulation is that a poor CQC rating—even when a fair judgment—can make things worse rather than better. Affected healthcare staff may experience emotional distress, including feeling ashamed, demoralised, and stigmatised, which may act as a barrier to improvement. And staff recruitment and retention, which are essential to improvement, may be more difficult when an organisation is reputationally damaged. In this sense, one element of the regulatory system (monitoring) is potentially destabilising another (improvement).

**Structural problems**

Despite the scale of current improvement efforts, it remains unclear whether they are tackling the right problems in the right way at the right level. Some issues in maternity services are deeply structural, including workforce shortages, poor quality estates and facilities, and inadequate technological infrastructure.

These require specific action backed by policy support and investment. But a disturbingly recurrent factor blamed for problems in quality and safety of care is culture. Simply exhorting colleagues to behave better towards each other and those they care for has had limited effect. More evidence based strategies for improving culture, including professionalism, civility, respectful communication, and anti-racist behaviours, are much needed.

Improving maternity care is a priority for families who use maternity services and staff who work in them. An evaluation of the CQC’s maternity inspection programme is under way, but a hard look at how “improvement” is currently being done and where efforts can add most value is now overdue. It will require rationalising and streamlining of current approaches, meaningful co-design in partnership with families and staff, and building an evidence base through rigorous evaluation.
New data platform for the NHS in England

Concerns include value for money and lack of public trust in the supplier

On 21 November, NHS England announced the procurement of a federated data platform (FDP) for the NHS in England. The FDP, which aims to join separate data sources from across the NHS, is now one of the largest and most ambitious health data infrastructure projects in the world. The £330m contract was awarded to the US software and analytics company Palantir.

That the NHS information infrastructure needs updating is undeniable. Yet, despite great promise, the FDP has been controversial from the start.

Much of the controversy can be attributed to lack of public trust in the procurement process and in the newly designated supplier. Palantir is controversial for several reasons; justifiable concerns continue about privacy and perceived potential commercialisation of NHS data. These add to a pre-existing trust deficit between NHS England and the public about how patient data are used.

**Shifting contract scope**

Two important concerns specific to the FDP are worth highlighting. First is the shifting scope of the contract: the original FDP contract specified its key functions as population health and planning, and patient cohorting or stratification—indirect uses of data. But FDP material released in the run-up to the announcement focused almost exclusively on the use of data for direct patient care. Direct care was also mentioned explicitly on NHS England’s Frequently Asked Questions web page before the announcement. After the announcement, however, the reference to direct care was removed and the information now states that the FDP will enable “clinicians to plan and deliver care more efficiently to improve patient care.” Despite this shift in emphasis, the national data opt-out—which allows patients to opt out of their confidential patient information being used for research and planning—will still not apply.

How a national FDP will deliver the implied improvements to patient care remains unclear. As it stands, proposed uses of data are justified on the basis of case studies involving Foundry, Palantir’s data and analytics platform, which is reported to have benefited trusts in local trials. It is not clear whether all such trials have been successful, or how the successful deployment of specific software by local trusts supports the case for a national federated infrastructure.

This lack of clarity has led some to question whether FDP use cases are based on a genuine system need that could be met by any potential supplier or whether they are instead based on services that Palantir is already—or could readily start—providing to the NHS through Foundry. Such concerns were recently exacerbated by a £25m contract awarded directly to Palantir, to “provide the smooth transition” of the existing platform to the FDP.

**Value for money?**

The second concern is what additional value the £330m of public money being spent on the FDP will bring. National data infrastructure already exists for many of the original FDP use-cases. The added value of the new FDP remains unclear, along with how (or whether) it will reduce friction and duplication of existing data flows. Furthermore, GP data will not be covered by the FDP, greatly reducing its use for population health and anticipatory care.

Locking national infrastructure—including capabilities from data access to analytics—into a single vendor comes with both costs and risks. If the £330m includes buying data science and analytics services, this might be at the expense of upskilling the NHS workforce. Should problems occur or priorities change at the end of the contract, migrating infrastructure and skills could incur enormous costs.

The FDP risks repeating past mistakes where central vision, executed without sufficient engagement or technical understanding, led to costly failures and abandonment. Usage is not mandated, so trusts and integrated care boards might choose not to participate in the context of bad publicity and lack of trust. Longer term, the public may be more likely to opt out of secondary data uses, compromising numerous other data and research initiatives, and the overall value of NHS data.

Questions around scope, value, and risk must be fully addressed. The FDP must be evaluated against specific performance targets related to added value, cost effectiveness, vendor lock-in, information exchange, usability and utility, and trustworthiness.

If targets are not being met, government support for the FDP must be removed. At a time when cost-cutting is the norm it is imperative that expenditure delivers demonstrable and sustainable benefits to patients and the NHS.
The plight of women and girls managing menstruation during humanitarian crises is below the radar of many aid organisations. But it’s a priority for ActionAid UK, the choice for The BMJ’s annual appeal this year—and the charity’s response to the September earthquake in Morocco shows why.

That earthquake, which killed 3000 people and left 300000 homeless, hit the remote Atlas Mountains—a very poor region that already had a high level of inequality, says Halima Begum, chief executive of ActionAid UK. This had led to widespread sexual exploitation through domestic work and meant that child marriage was a constant risk.

She says, “Thousands of women and girls are now living in rudimentary shelter without access to menstrual products, either because of lack of availability or lack of funds to buy them, and without access to facilities to wash their clothes.”

“Far too many marginalised women are forced to use torn pieces of clothing or dirty rags instead of safe, clean period products, and this puts them at risk of dangerous infections. Having bloodstains on your clothes causes embarrassment and isolation.”

Jane Feinmann reports on ActionAid UK, which champions women’s rights during humanitarian crises.

“Periods do not stop for disasters”

“The gender inequality and discrimination that women and girls experience in their daily lives continues when disasters occur. That’s why we have to do things differently.”

Mike Noyes, head of ActionAid UK’s humanitarian team in emergencies, adds, “Periods are a very normal thing with women, so we shouldn’t have to feel ashamed,” says Arwa, a 17 year old student living in Amizmiz, one of the towns that suffered huge damage during the earthquake. “But only men organise everything, and we as women don’t have this ability to tell them about what we need.”

One of ActionAid UK’s first moves after the earthquake struck was handing out “dignity kits” to 1000 women in the most remote areas: period products, underwear, toothbrush and paste, and a hairbrush, contained in a backpack at a total cost of £8.70 each. This handout is being repeated: “We expect to be here for months,” says Noyes.
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Period poverty is part of ActionAid’s wider work with local partners to support women’s resilience and leadership capacity

ActionAid UK has had a presence in Morocco for 20 years, partnering with local non-governmental organisations. Notably, these include Entreprise Sociale au Maroc, which was set up 16 years ago to promote social and professional integration of disadvantaged women in rural areas, in line with its long term policy of prioritising women in localised decision making.

Through its local partners ActionAid has supported wider relief efforts to provide food, water, and clothing in the aftermath of the Morocco earthquake. “There’s a huge effort now to provide safe places for those still displaced to live during the winter,” says Begum.

This effort also involves education. Each dignity kit includes leaflets printed in Arabic and Berber, providing guidance on protection from sexual exploitation and abuse. “Typically, more women and girls [than men] are killed by rapid onset disasters like tsunamis and earthquakes,” Begum explains, “and violence against women increases during all emergencies. There is nothing natural about this increased vulnerability. It is the result of the gender inequality and discrimination that women and girls experience in their daily lives.”

Global problem

In Kenya, ActionAid UK hands out period products to support girls who might otherwise be at risk of dropping out of school. It distributes these in camps for people displaced from Somalia, who have been living with no private toilets or clothes washing facilities since devastating droughts in 2017.

Roya, 21, and her mother were among thousands of people routinely handed period products when they arrived at the charity’s Women Friendly Space on the Greek island of Lesbos after crossing from Afghanistan. “My mother got her period on the journey, and she had nothing with her,” Roya told ActionAid UK. “She had to rip a dirty piece from her dress and use that.”

ActionAid UK also campaigns on menstruation issues in the UK. A May 2023 poll by the charity reported that more than one in five women and girls struggled to afford period products (21%, up from 12% a year earlier). Additionally, 17% of respondents stayed at home because they didn’t have tampons—missing out on school, work, exercise, and socialising.

Changing the world with women and girls

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On every bedside locker at the Royal Berkshire Hospital is a sticker bearing a phone number for the Call 4 Concern service. This information, also on banners and posters around the corridors of the Reading hospital, urges patients or family members to call for help if they are worried about a patient’s changing condition. One call triggers an independent clinical review.

Call 4 Concern launched at the Royal Berkshire in 2009. The service is available around the clock seven days a week and is provided by the nurses on the critical care outreach (CCO) team. Other hospitals have since implemented this or similar approaches.

Soon, the notices, which advise relatives first to speak to a ward nurse or doctor before calling, could be a familiar sight in all hospitals in England: the service is prompting interest in the wake of the campaign for Martha’s rule.

The parents of 13 year old Martha Mills watched her die in a London hospital after staff failed to listen to their concerns. They have called for action modelled on Call 4 Concern.

Calling the number can produce fast action. Last summer, a 19 year old patient was whisked to the intensive care unit (ICU) from the renal ward after his mother called the Call 4 Concern service to say his condition was deteriorating. “She was worried he was getting worse and she wasn’t sure what was going on,” says Alison Schofield, lead nurse for the CCO team and an advanced nurse practitioner in critical care.

“At within two hours of that call we had taken him to ICU for dialysis.”

CCO teams are a part of many hospitals and offer intensive care skills to patients with, or at risk of, critical illness outside the ICU. This is most likely to be on general wards but can be at any location.

At the Royal Berkshire, the team is staffed by advanced nurse practitioners and clinical nurse specialists, all of whom can assess, order tests, and prescribe. The team members spend their time going around the hospital reviewing and following up the sickest patients outside the ICU.

Call 4 Concern is a relatively small—although slowly growing—part of the CCO team’s work.

Most referrals to the team come from clinical staff after a patient has triggered a national early warning score of 5 or above, or if they feel concerned about a patient, explains Schofield.

The scheme gives patients or their relatives the same access to this team as a clinical referral. “Relatives can phone us day or night if they have concerns,” Schofield says.

“We triage it alongside our other workload. We assess the patient, talk to the nurses, look at the notes, and come up with a treatment plan. We then feed back to the patient and their families about what we’ve done.”
Little things, big difference

In most instances, the CCO team does alter the treatment plan in some way when assessing a patient after a Call 4 Concern referral, but it doesn’t tend to be a drastic change. It could be a dietitian review or starting intravenous fluids. “It’s little things that can make a big difference,” Schofield says.

If escalation is needed, the CCO nurse can contact ICU for a rapid review. In the past 18 months, only one patient, the young man from the renal unit, has been moved to ICU after a call from a concerned relative.

Family referrals take longer to deal with than clinical ones, Schofield says. “They are more complicated and more emotional,” she says. “When people call, they feel at the end of their tether.”

The hospital has found that the service is generally not abused or overused by relatives, although the number of calls is slowly increasing. When the service started it averaged about six to eight calls a month—today it is around 14 and has peaked at 18. While there could be several factors behind this, the pressure on the system is likely to be part of it. “The NHS is very busy and stretched, we’re all under a lot of stress and things get missed because of the volume of work,” says Schofield.

Most calls come between 12 pm and 2 pm, and 8 pm and 10 pm, after visiting hours have finished. “When families are visiting in the evening, staff are often busy and don’t have time to give information,” says Schofield.

Family referrals are more complicated and more emotional

Battle against hierarchy

Call 4 Concern was created by Mandy Odell, a consultant nurse in critical care who has since retired. She was responsible for launching the Royal Berkshire CCO team in 2001, later adding the Call 4 Concern element.

“I had the idea after being called by a nurse to see an older lady who was deteriorating,” Odell tells The BMJ. “Either side of her were her two daughters. I said, ‘We need to refer her to ICU,’ and they said, ‘Thank you so much, you’re the only person who has listened; we’ve been so worried for two or three days. Mum is not herself and they haven’t listened to us.’”

This made her think about the importance of taking on concerns from relatives as they know the patient best. “Families know that something is not right,” she says.

While she had the full backing of ICU consultants, her work with both the CCO team and Call 4 Concern was not universally welcomed. “The response was mixed. We had some doctors rip our notices off the wall; some doctors told their juniors not to call us.”

The culture and staff hierarchy on some wards made their work harder. “But staff started to call secretly,” Odell says. “I would get whispered calls saying, ‘The consultant doesn’t want me to contact you, but I’m worried about this patient.’ I would say I just happened to be walking past the bed when I noticed this patient looked a bit grey.”

PATIENT CASE STUDY: “Now that I have that phone number, I know it will be alright”

Richard Huff spent five weeks in the Royal Berkshire NHS Foundation Trust’s ICU at the end of 2015. His daughter Bethany feels that her concerns about his condition following emergency abdominal surgery were not listened to.

It was only at the end of Richard’s ICU stay that Bethany learnt about Call 4 Concern—if she had been able to call the afternoon she started to worry, 12 hours before Richard was admitted to ICU with sepsis and organ failure, both believe he might have avoided deteriorating so much.

“Call 4 Concern is such an important service,” Odell tells The BMJ. “When people call, they feel at the end of their tether.”

The hospital has found that the service is generally not abused or overused by relatives, although the number of calls is slowly increasing. When the service started it averaged about six to eight calls a month—today it is around 14 and has peaked at 18. While there could be several factors behind this, the pressure on the system is likely to be part of it. “The NHS is very busy and stretched, we’re all under a lot of stress and things get missed because of the volume of work,” says Schofield.

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Mandy Odell
Gradually the team and their different referral routes became a well established and welcomed part of the hospital. Odell says it is a sign of the positive culture at the trust that senior leaders backed the scheme.

The team still works to flatten the traditional staff hierarchy so that they are approachable by doctors, nurses, and families. “When junior doctors were leaving to go to a hospital without an outreach service they were devastated,” she says. “It has saved lives.”

Audit demonstrates success

Seven years after launching Call 4 Concern, Odell did an audit of the 70,000 calls that the CCO team had dealt with in that time. “A very small number of calls come from Call 4 Concern,” Odell says.

She found 534 calls to the CCO team—less than 1%—came from families or patients, concerning 312 patients. (The rest came from hospital staff.) Some families got in touch several times, with 46 calls about one patient with chronic, complex conditions over a number of years.

Only 8% of these 534 calls came from patients themselves. The most common family member callers are daughters, followed by wives and then mothers, although very few are about child patients. Calls come from all over the hospital, but most are from medical wards. This study, published in the British Journal of Nursing in 2019, showed that Call 4 Concern flags didn’t lead to a big increase in the workload of the team, despite significant concerns that it would.

In fact, what Odell worries about is the opposite—that many people who could benefit simply don’t know it is available (see box, p 351). “One of the main problems is making sure it is properly advertised,” she says.

Eyes and ears

For Jodie Smythe, consultant in critical care at the trust, the CCO team are the “eyes and ears” of the ICU across the hospital.

If the CCO team hadn’t been in place, she wouldn’t have chosen to work at the trust, she says. “It was really important to me. They support and empower the nurses, they are a link between sick patients in hospital and intensive care,” Smythe says. It is important for doctors not to be defensive if their patients are reviewed. “Don’t take it as an affront or a criticism,” Smythe says. “There is no harm in a fresh pair of eyes.”

For those looking to implement an approach such as Call 4 Concern, having a critical care outreach team is an essential first step, say those involved at Royal Berkshire. NICE data showed in 2018 that most hospitals, but not all, have a CCO team, and that there is a lot of variety in staffing, how they are accessed, and the hours they are available.

Senior medical and nursing support is essential to establish both a CCO team and Call 4 Concern service, Odell says. Recruiting enough nurses with the right skills to provide a round-the-clock team is also challenging, and the Royal Berkshire has trained its own staff.

Smythe points out that the service is not available equitably to all. For those with poor health literacy, literacy, or English, and those who don’t have relatives present, the service may not be accessible.

For Steve McManus, chief executive of the trust, this highlights why Call 4 Concern is not a panacea for solving all patient safety problems, but a valuable tool that needs to reflect a wider culture.

“It is not a silver bullet,” he says. “It can’t be used as a sticking plaster for a less positive culture—that is missing the point. We want to create positive culture around safety and part of that is valuing the patient and family voice. It’s an important part of our safety environment, but it is only one part.”

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