Staff caring for tracheotomy patients need training

Ingrid Torjesen LONDON

Patients who have undergone a tracheotomy are often cared for on general wards by staff who have not been trained in their needs or in how to deal with common emergencies, says a report issued by the UK National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

As tracheotomy has become more common in recent years, the procedure is increasingly taking place on critical care wards rather than in operating theatres, and patients are then often discharged to a general ward. However, many staff involved in the care of these patients do not have the skills required, which could compromise the care, NCEPOD found.

Furthermore, hospitals do not regularly record that tracheotomies have taken place, which makes auditing the care difficult and prevents effective forward planning. When hospitals in England, Wales, or Northern Ireland were asked how many procedures they carried out during the 11 week inquiry study period (25 February to 12 May 2013), of which 426 procedures were selected for review. The inquiry also assessed 553 ward questionnaires returned for patients who had a stay in both a critical care and general ward.

Kathy Wilkinson, NCEPOD’s clinical coordinator in anaesthesia and the report’s lead author, said, “We know that tracheostomy training must be improved, but without better coding and national data collection we cannot target the problem areas. Our study also revealed that tubes often become dislodged or blocked, highlighting the importance of good ongoing care, which was often below standard.”

To reduce the risk of such events, it is essential that the right tube is used, NCEPOD recommends. Although a third of the patients (29.6%) were obese, a factor known to make insertion more difficult, adjustable length tracheostomy tubes were used in only 10.1% of patients. Less than two thirds of hospitals (63.7%) reported a stated level of competency for staff caring for a patient with a tracheostomy. The proportions were half (52%) for difficult tube changing and 72.1% for the management of blocked or displaced tubes.

Cite this as: BMJ/2014;348:g3827

End top-down changes to NHS and let organisations innovate, says think tank

Zosia Kmięciowicz THE BMJ

Politicians should loosen their grip on the day to day management of the NHS and allow organisations to initiate improvement from within, a new report from the health policy think tank the King’s Fund has urged.

Chris Ham, the think tank’s chief executive and the author of the report, argued that intervening in management of the NHS and prescribing changes from the centre of government had hampered rather than nurtured reform.

The report said that the intentions in the Health and Social Act 2012 to distance ministers from the operational management of the NHS have failed to be realised. “Regardless of which political party is in government, there appears to be an irresistible tendency for ministers to want to be seen to be leading the NHS, driven by intense media scrutiny and the Secretary of State’s ultimate accountability for the performance of the NHS,” said Ham in the report.

Because targets and performance management can achieve quick results, politicians revert to this approach when they are under pressure, he added.

Even foundation trusts, which were originally designed to be independent of the Department of Health, now “are as likely to look up to regulators, as out to the communities they serve,” said the report. To give local NHS leaders the space to innovate and lead changes to services, the role of ministers in determining funding, establishing priorities, and providing accountability to parliament needed to be clarified, said Ham.

The report called for the NHS to rely on locally derived improvements and changes from within organisations rather than the large scale structural reorganisations that have been imposed on the NHS over the past 25 years. Ham said, “Transforming the NHS depends much less on bold strokes and big gestures by politicians than on engaging doctors, nurses, and other staff in improving care.

Learning from high-performing health organisations here and abroad, we can move away from top-down change to locally derived solutions.”

Cite this as: BMJ/2014;348:g3832
IN BRIEF

Child poverty targets will be missed: By 2020, 3.5 million children in Britain (21%) will be living in absolute poverty (defined as households with less than 60% of median income for 2010-11, adjusted for inflation). This is more than four times the 5% target set under the Child Poverty Act 2010, the Social Mobility and Child Poverty Commission said in a report that was highly critical of government inaction.1 To reach the targets set out in the act would require nearly 100% parental employment rates, which have never been achieved in the United Kingdom or elsewhere in the world, the report said.

Living organ donations increase: The number of living organ donations assessed by the Human Tissue Authority reached 1290 in 2013-14, up from 1243 in 2012-13, new figures have shown. The most common donation was a kidney (1234), and there were 48 liver lobe donations. “Altruistic” donors (those who had no prior relationship with the recipient) last year totalled 139, up from 104 in 2012-13.

Quebec physician assisted suicide: The Canadian province of Quebec has become the fourth and largest jurisdiction in North America to legalise physician assisted suicide. Bill 52, the Law Concerning End of Life Care, went beyond US legislation in America to legalise physician assisted suicide. The law was passed by 96 votes to 22 and has broad public support.

Security measures are stepped up in Beijing hospitals: In Beijing, counterterrorism security measures in the 21 hospitals directly managed by municipal authorities will be stepped up, local media have reported. Stab-proof vests and other protective gear will be provided to hospital security guards, while laboratory security and access to hazardous materials such as radioactive chemicals and drugs will be tightened.

Some cancers are more prone to delayed diagnoses: A survey of 2371 patients with 15 different cancers found that 48% of prostate cancer patients and 37% of rectal cancer patients reported a delay of three months or more between first noticing symptoms, such as rectal bleeding, and going to see a doctor, compared with 8% of breast cancer patients.2 The study was published in the British Journal of Cancer.

Cite this as: BMJ 2014;348:g3825

A third of adults in England have “prediabetes”

Jacqui Wise LONDON

More than a third of adults in England now have prediabetes, and the prevalence has tripled over the past eight years, new research concludes.1

The authors warned that there would be a steep rise in the incidence of diabetes if action were not taken to stop the “extremely rapid” rise in prediabetes. Between 5% and 10% of people with prediabetes progressed to diabetes every year, and people with higher than normal blood glucose concentrations were at risk of vascular, kidney, and eye problems, it said.

The research, published in the online journal BMJ Open, shows that the prevalence of prediabetes rose from 11.6% in 2003 to 35.3% in 2011. The finding came from an analysis of 20 000 people who took part in the Health Survey for England and provided a blood sample.

Prediabetes was classified as a glycated haemoglobin concentration of between 5.7% and 6.4% in people who had not previously been given a diagnosis of diabetes. This is one of the components used in the American Diabetes Association’s definition of the condition. Diabetes itself is usually classified as a glycated haemoglobin of 6.5%. The prevalence of diagnosed diabetes rose from 3.6% in 2003 to 5.6% in 2011, the study said.

Older age, overweight, obesity, blood pressure, and a high cholesterol concentration were all associated with the risk of prediabetes, the study said. By 2011 half (50.6%) of people aged over 40 years old who were overweight (with a body mass index of 25 or over) had prediabetes. There was no difference in the proportion between the sexes.

The prevalence of prediabetes varied by ethnic group, the study found, although in all groups of adults, irrespective of body mass index, the prevalence was at least a fifth. People living in the most deprived areas of England were more likely to have prediabetes in 2003 and 2006, but the association was no longer significant in 2009 and 2011.

The lead author, Arch Mainous, from the Department of Health Services Research Management and Policy at the University of Florida, and his coauthors warned, “This rapid rise in

Economic recession may have caused 10 000 extra suicides

Adrian O’Dowd LONDON

Around 10 000 extra suicides in the Western world from 2008 to 2010 were highly likely to be related to the recent economic recession, a study has concluded.1

The study, by the University of Oxford and the London School of Hygiene and Tropical Medicine, was published in the British Journal of Psychiatry on 12 June. It said that suicide rates had risen significantly across Europe, Canada, and the United States since 2007 and that the increase was four times higher among men. However, it noted that certain interventions, such as return to work programmes and prescribing antidepressants, could help to lessen the risk of suicide in hard economic times.

The researchers analysed recently released data on suicide from the World Health Organiza-
A third of adults in England have “prediabetes”

Lords to consider bill on assisted suicide

Such a short period of time is particularly disturbing because it suggests that large changes on a population level can occur in a relatively short period of time.”

John Yudkin, emeritus professor of medicine at University College London, commenting on the findings, said that the label of “prediabetes” was an example of overdiagnosis. He said, “The category of ‘prediabetes’ has been defined by the American Diabetes Association as a measure of glycaemia (fasting, post-glucose load, or HbA1c) intermediate between clearly normal and diabetes. It is a term which has been rejected both by NICE [the UK National Institute for Health and Care Excellence] and the World Health Organization ‘to avoid any stigma associated with the word diabetes and because many people do not progress to diabetes as the term implies.’

“The rising global prevalence of diabetes and obesity are a major challenge to public health. But the label of ‘prediabetes’ applied to individuals is an example of overdiagnosis, recognising that most people so categorised will not develop diabetes, and that the term brings with it the burden of disease labelling and risks of largely unproven interventions.”

Cite this as: BMJ 2014;348:g3791

Lords to consider bill on assisted suicide

Charles Falconer’s bill could have a second reading in July

Clare Dyer BMJ

A bill to legalise physician assisted suicide in England and Wales has been tabled again in the House of Lords, and this time peers are expected to have a chance to vote on the proposals.

The Assisted Dying Bill was introduced last year by Charles Falconer, a former Labour lord chancellor, but time limiting problems prevented it from getting any further. ¹

The reintroduced bill could have a second reading debate as early as July. If supported in the House of Lords—where formidable opposition has greeted previous attempts to legalise assisted suicide—it will pass to the House of Commons, where opinion is thought to be more favourable.

The UK government has made it clear that it would not stand in the way of a change in the law, and Conservative and Liberal Democrat MPs and peers, including ministers, will be allowed a free vote. Norman Lamb, the minister responsible for care for elderly and disabled people, has said that he would vote in favour.

The bill, which is based on a similar law in Oregon, would allow doctors to prescribe a lethal dose of drugs for terminally ill patients who are deemed to have no more than six months to live. Patients would decide whether and when to take the drugs.

Two doctors working independently of each other would have to satisfy themselves that the patient had a clear and settled intention to die and was not being coerced by others.

Peers who have signalled their opposition to the bill include Sheila Hollins, a past president of the Royal College of Psychiatrists, who argued in the Daily Telegraph that “there are no possible safeguards that would protect vulnerable, sick and elderly people.”

The Scottish parliament’s health and sport committee has been taking evidence on the Assisted Suicide (Scotland) Bill.

Cite this as: BMJ 2014;348:g3798

Anal cancer deaths quadruple in UK

Jacqui Wise LONDON, UK

The rate of anal cancer in women has risen steeply since the mid-1970s, from 0.4 per 100 000 to 1.8 per 100 000 in 2009-11, according to new UK figures. ² Cancer Research UK’s figures show that cases of anal cancer in men have also risen, from 0.4 per 100 000 in 1975-77 to 1.2 per 100 000 in 2009-11.

In 2011 there were 1175 new cases of anal cancer in the United Kingdom: 414 in men and 761 in women, giving a male:female ratio of around 10:18. The latest figures also show that death rates for anal cancer have more than quadrupled since the mid-1970s, with around six people dying every week from the disease in the UK. In 2011 there were 299 deaths from anal cancer in the UK: 113 in men and 186 in women.

Nick Ormiston-Smith, Cancer Research UK’s head of statistics, said, “These are very worrying findings and highlight an increase in a cancer that’s not often talked about. Around 1200 people are diagnosed with cancer of the anus every year in the UK, which means it’s still relatively rare. But the rise in incidence, particularly in women, is concerning.”

The rise is believed to be linked to the increasing prevalence of the human papillomavirus (HPV). An estimated 90% of anal cancer cases in the UK are linked to HPV infection. The introduction of the HPV vaccine for girls is expected to help reduce the rates of HPV related cancers in the UK in the future. The Joint Committee on Vaccination and Immunisation is currently considering whether to extend the vaccination programme to boys.

Research into sexual attitudes has indicated that more heterosexual couples are having anal intercourse, which may account for the higher rates of the disease among women. ² Smoking is also a risk factor for the disease; and although smoking rates have fallen since the 1970s, the drop has been smaller in women than in men.

Cite this as: BMJ 2014;348:g3809

Actress Farrah Fawcett campaigned to raise awareness of anal cancer before her death from it in 2009

Cite this as: BMJ 2014;348:g3747

PAUL ELLIS/AFP/GETTY
Emergency doctor is struck off over “catalogue of failures” and dishonesty

Clare Dyer  THE BMJ

An emergency medicine doctor has been struck off after a fitness to practise panel found him responsible for a “catalogue of failures” involving patients, including failing to assess them properly, missing detectable fractures, prescribing inappropriate drugs, and failing to refer patients to the appropriate specialists.

Fazal Haque, a middle grade doctor in the emergency department at Princess Alexandra Hospital in Harlow, Essex, was also rude and argumentative with colleagues and patients and behaved dishonestly on eight separate occasions, the Medical Practitioners Tribunal Service found.

Shift managers’ reports written by several different nurses related how emergency room shifts had been rendered difficult by Haque’s behaviour, which included refusing to see patients or seeing them out of turn. On one occasion Haque entered a room occupied by a patient, removed his socks, and began washing his feet in a sink. When the patient asked what he was doing, Haque told him to “shut up.” The shift manager, who came into the room at this moment, recorded the incident in her report but later found the report missing from her cupboard. Haque admitted taking the document, telling her that he wanted the incident to go no further.

Other dishonest acts included claiming in notes that he had seen a patient when he had not, editing patients’ notes retrospectively, claiming time off for a course he never attended, and undertaking locum work while suspended without notifying his employers.

Among the clinical findings, the panel expressed particular concern over Haque’s failure to treat a 17 month old child with febrile convulsions, exposing her to the risk of permanent brain damage.

Haque did not attend the hearing but sent in several emails accusing his former colleagues of making false allegations. The fitness to practise panel’s chairwoman, Michele Codd, said that the tribunal had “noted a pattern of blanket denials and acts of dishonesty, taken together with “a persistent lack of insight” and “widespread failings in his clinical care and his lack of remediation which indicate a risk to patient safety,” were “fundamentally incompatible with him continuing to hold medical registration.”

Cite this as: BMJ 2014;348:g3815

Benefits of trastuzumab outweigh its harms, says Cochrane review

Jacqui Wise  LONDON

The benefits of trastuzumab (marketed as Herceptin) outweigh the increased risk of heart problems in women with metastatic breast cancer, a systematic review has concluded.1

The monoclonal antibody reduces overall mortality from breast cancer by one fifth after two years of follow up, but the risk of heart toxicity is between three and four times more likely than in regimens that did not include the drug, concludes the review published in the Cochrane Library.

Overexpression or amplification of HER2 receptors is seen in about a fifth of women with breast cancer, and these forms of breast cancer tend to be more aggressive. Trastuzumab has been recommended for treating women with HER2 positive advanced breast cancer since 2002 in the UK and since 1998 in the US.

The researchers, from the Italian Cochrane Centre, reviewed data from seven trials that had a total of 1497 women with advanced stage breast cancer who tested HER2 positive. The women were given trastuzumab in combination with other drugs, either as a first line treatment or later when their cancer had progressed. All the studies found that trastuzumab extended time to disease progression, with gains varying between two and 11 months. In five studies the drug extended time to death by between five and eight months when compared with other treatments. The drug was most effective when it was used as a first line treatment or in combination with taxanes.

However, the review found that some patients developed congestive heart failure during treatment. With standard therapies, 300 in every 1000 women survived at two years and 10 women developed heart problems. When trastuzumab was added in, 373 survived but 35 developed heart problems that necessitated immediate discontinuation of treatment. However, the cardiac problems were usually reversible if treatment was stopped immediately, and the authors said that women with advanced disease might choose to accept this risk.

One particular drug combination was associated with a higher risk of heart problems. “Some of the earlier trials combined trastuzumab with a class of drugs called anthracyclines,” said Roberto D’Amico, director of the Italian Cochrane Centre, at the University of Modena and Reggio Emilia, and a coauthor of the review. “This combination is not

Cite this as: BMJ 2014;348:g3744

Service redesign “should be tested as rigorously as new treatments”

Tom Moberly BMJ CAREERS

Changes in service delivery should be subjected to the same rigorous testing as new treatments undergo, NHS England’s chief executive, Simon Stevens, has argued.

Speaking at the NHS Confederation’s annual conference in Liverpool on Wednesday 4 June, Stevens said that the NHS “should be rigorously pro-research” and suggested that such an approach could enable the NHS to become a world leader in health service innovation.

The NHS had a poor record of evaluating service changes, he told delegates. The service now needed to “accelerate the redesign of care delivery” through “some well controlled experimentation.” He explained, “We don’t apply the same discipline to the way we go about innovating in our service delivery that we would expect clinical professionals to apply in their own workplace. We do too many pilots that are not rigorously conceptualised and effectively managed.”

The NHS’s new “integrated care pioneers” programme (www.england.nhs.uk/2013/11/01/interg-care-pioneers) would benefit from more stringent testing, Stevens said. “What I would really like to see is a more quasi-experimental model of that and say, ‘This is the intervention; this is the hypothesis about what we’re going to do; this is the control or what the comparisons are going to be,’ and actually get much more quantitative about how we do new things in the NHS.”

Cite this as: BMJ 2014;348:g3744
Proton beam therapy benefits few cancers, US guideline says

Michael McCarthy SEATTLE

Although proton beam therapy is appropriate in situations where it is not possible to spare surrounding normal tissue using standard photon based radiotherapy, routine insurance coverage should be reserved for treating relatively rare malignancies such as ocular tumours and paediatric brain tumours, says a new policy document from the American Society for Radiation Oncology (ASTRO).1

In its “model policy” document the society detailed which diagnoses met ASTRO’s evidence based standards and when they should be covered by private and government insurance. In a statement Colleen Lawton, chairwoman of ASTRO’s board of directors, said that it was important for the society to provide “balanced, evidence based guidance to payers that ensures access to [proton beam therapy] for cancer patients while being judicious stewards of our nation’s and our patients’ financial resources.”

Proton beam therapy allows for much more precise targeting of tumour tissue than standard photon x ray therapy, but it must be administered in facilities that typically cost $150m (£89m) or more, making treatments far more expensive.

The ASTRO policy document recommended two coverage groups for proton beam therapy; one for diagnoses for which the treatment had been shown to be effective, and another for diagnoses whose evidence of effectiveness was “still emerging.” For diagnoses in this second group, it recommended coverage for patients who were in a clinical trial or enrolled in a registry that allowed for the collection of clinical evidence.

Malignancies in the first group included ocular tumours, such as intraocular melanoma; tumours that approach or are located at the base of the skull; primary and metastatic tumours of the spine when the radiation tolerance of the spinal cord may be exceeded with conventional treatment or when the cord has been previously irradiated; primary hepatocellular cancer treated in a hypofractionated regimen; and primary or benign solid tumours in children treated with curative intent and for palliative treatment of childhood tumours when proton beam therapy allows sparing of normal tissue or provides added clinical benefit.

Diagnoses that fell into the second group included head and neck, thoracic, abdominal, and pelvic malignancies including genitourinary, gynaecological, and gastrointestinal carcinomas.

The policy found that evidence of the comparative efficacy of proton beam therapy in treating prostate cancer was “still being developed.” It concluded, “In order for an informed consensus on the role of [proton beam therapy] for prostate cancer to be reached, it is essential to collect further data, especially to understand how the effectiveness of proton therapy compares to other radiation therapy modalities such as [intensity modulated radiation therapy] and brachytherapy.”

Cite this as: BMJ 2014;348:g3786

CQC says it failed to respond adequately to concerns about care home deaths

Susan Mayor LONDON

The Care Quality Commission failed to respond to early warning signs of problems and took too long to recognise and act on risks to resident at a care home in West Sussex An inquest subsequently found that neglect had contributed to the deaths of five people there and that other residents experienced “suboptimal” care, the CQC has found in an analysis of its role in the case.1

The CQC’s report comes after a serious case review carried out by West Sussex Adults Safeguarding Board that found that the CQC’s assessment of the care home, Orchid View, was inadequate.2

Andrea Sutcliffe, the CQC’s chief inspector of adult social care, said, “While the responsibility for the unacceptable care that happened at Orchid View rests squarely with the people providing the service and its owners, it is clear that in 2010-11 the CQC did not fulfil its purpose of making sure the service provided people with safe, effective, compassionate, high quality care.”

Since the closure of Orchid View in 2013 she considers that the CQC is now more responsive to safeguarding and other notifications of risk. “But we can and should do more,” she said. The report used root cause analysis to identify the key points where CQC was involved, what action it took, and alternative action that could have been taken.

Cite this as: BMJ 2014;348:g3843
Andy Haines
Enquiring, eclectic, cautious

What is your pet hate?
“Conspicuous consumption, as exemplified by the epidemic of bloated cars clogging London’s streets.”

What was your earliest ambition?
To become a doctor.

Who has been your biggest inspiration?
Our family GP, the late Gwyneth Olive, who inspired me to become a doctor. She worked singlehandedly, delivered me (apparently it was difficult), and treated me at home for pneumonia as a child.

What was the worst mistake in your career?
It occurred when I was a junior doctor working unsupervised in an emergency department overseas. The experience taught me humility, the importance of local knowledge, and to be ready for the unexpected.

What was your best career move?
Working with Julian Tudor Hart and Tom Meade early in my career gave me an opportunity to pursue clinical medicine in general practice and public health. Being based at the London School of Hygiene and Tropical Medicine has given me unparalleled opportunities to work on global issues.

Who is the person you would most like to thank and why?
Where do I start? There are so many people to thank, but my family deserves special gratitude for supporting me for many years.

To whom would you most like to apologise?
Apologies are best given in person and promptly, so if I didn’t do so at the time it’s doubtful I can make amends now for any unintended harms I may have done in the past.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
Health is a difficult brief to master for a politician without any background in the area, and perhaps as a consequence policies are often based more on ideology than on evidence. Lansley’s performance stands out as being particularly lamentable. Frank Dobson was underrated by some because he didn’t “reform the NHS,” but he was probably the best that I can remember. There are some good examples of effective health ministers from countries such as Mexico (Julio Frenk) and Ethiopia (Tedros Adhanom Ghebreyesus and Kesetebirhan Admasu).

If you were given £1m what would you spend it on?
After the inevitable party to celebrate, I would give half of it to fund work on climate change and health, and I would split the rest between charities that I support, such as Marie Curie Cancer Care, Medact, the Multiple Sclerosis Society, and THET (Partnerships for Global Health).

Where are or were you happiest?
With family and friends—particularly in Galicia, northwest Spain, whence one branch of my wife’s family originated.

What single unheralded change has made the most difference in your field in your lifetime?
Changes in technology and increasing openness to the contributions of different disciplines have revolutionised the way research is organised. Collaborating across disciplines and continents to study complex problems of global health is increasingly becoming the norm.

Do you believe in doctor assisted suicide?
I fully support efforts to improve palliative care, but I am also sympathetic to the argument that, in some cases, more needs to be done to relieve suffering. We should learn from international experience about the best way to do so and make it easier for patients and their loved ones to get the help that they need.

What book should every doctor read?
A Country Doctor’s Notebook by Mikhail Bulgakov. The stories convey the stress and isolation of the ill prepared newly qualified doctor’s first posting in a remote hospital, but they are also suffused with great warmth and humanity.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Dylan Thomas’s “Do not go gentle into that good night . . . Rage, rage against the dying of the light”—but no mourning will be allowed.

What is your guiltiest pleasure?
I enjoy visiting other countries, but often it’s difficult to avoid air travel.

What personal ambition do you still have?
To contribute to tackling climate change.

Summarise your personality in three words
Enquiring, eclectic, cautious.

Where does alcohol fit into your life?
Intermittently and in moderate amounts.

What is your pet hate?
Conspicuous consumption, as exemplified by the epidemic of bloated cars clogging London’s streets.

Cite this as: BMJ 2014;348:g3801

ANDY HAINES 67, is an epidemiologist with a special interest in primary care and the climate’s impact on health. He was an academic GP at University College London from 1987 to 2000, and then until 2010 he was the director of the London School of Hygiene and Tropical Medicine, which in 2009 was the first UK institution to win the Gates Foundation’s $1m Award for Global Health. His research has focused on how the effects of climate change can be mitigated by using low carbon technologies and how policies on transport, energy, food, agriculture, and housing can have health benefits.