this week

LIFE IN VIEW//SPL

Seven day NHS needs 4000 doctors

Up to 4000 more doctors will be needed to staff seven day services in the NHS in England, a leaked report has said.

The internal Department of Health report, leaked to the *Guardian*, said that 11 000 more staff would be needed, including 4000 more doctors (1600 consultants, 1500 registrars, and 900 junior doctors). These numbers were "calculated by increasing the number of staff at the weekend . . . to match weekdays."

A seven day service would cost an additional £900m a year after "benefits such as reduced length of stay and reduced admissions" were taken into account, said the report, quoting figures from an unpublished report, commissioned from the consultancy group Deloitte.

The Conservatives pledged a seven day service during their election campaign, along with a commitment to recruit 5000 more GPs by 2020, which the report admits will be "challenging."

The report said that it was not possible to "evidence the mechanism by which increased consultant presence and diagnostic tests at weekends will translate into lower mortality and reduced length of stay."

Mark Porter, the BMA's chair of council, said that the association had repeatedly asked the government to outline how it would fund and staff a seven day service. The government "has cynically tried to portray doctors' contracts as a roadblock," despite several NHS trust chief executives confirming that introducing more seven day services in their hospitals did not require a change in contracts, he said.

"This leaked document makes it clear that more seven day services will require not only thousands of extra doctors, nurses, and support staff but an additional investment in both the NHS and community care. Its findings also show no proven link between weekend mortality rates and consultant presence."

The Department of Health declined to provide a copy of the report but issued a statement saying, "There is clear, independent clinical evidence of variation in the quality of care across the week, and working together with the NHS we are determined to tackle this problem. Making sure the right staff and support are available for all patients seven days a week is a key part of our approach."

Ingrid Torjesen, London

EDITORIAL, p 260

Cite this as: *BMJ* 2016;352:i997

An extra 1600 consultants, 1500 registrars, and 900 junior doctors are needed to provide a seven day service

NEWS ONLINE

- Sharp spike in deaths in England and Wales needs investigating, says adviser
- Groups call for halt to "dangerous trial" that nearly doubles work hours for doctors
- Interstitial lung abnormalities are linked to increased risk of death

SEVEN DAYS IN

England gets extra £1bn a year for mental health

Around £1bn more a year will be spent on improving mental health services in England in the wake of what is being called a landmark report that described a service that still left hundreds of thousands of people with "ruined" lives.

The scale of long term underfunding, neglect, marginalisation, and inadequate service provision was made clear in the NHS commissioned but independent Mental Health Taskforce's report, published on 15 February.

The government and NHS England have agreed with the report's recommendations and said that more than £1bn a year of extra funding would be invested in this area of NHS care by 2020-21, to reach one million more people.

In a wide ranging set of recommendations, the report's authors proposed a multifactorial approach over the next 10 years to improve care through prevention, expansion of mental healthcare, such as seven day access in a crisis, and integrated physical and mental healthcare.

Although mental health services had been improving over the past 50 years, the current situation was unacceptable, said the authors. Although access to psychological therapies had improved much in recent years, it said, only 15% of people who needed care currently received it.

It recommended that an additional 600 000 people should get access to these therapies by 2020 and that more be done to help people with anxiety and depression to find or keep a job.

It also recommended that by 2020 at least 280 000 more people with severe mental health problems should have better support for their physical health through screening.

Adrian O'Dowd, London Cite this as: *BMJ* 2016;352:i933

In the dock

GP is suspended over zopiclone prescriptions

A GP who prescribed 28 zopiclone sleeping pills to an elderly patient to push through the letter box of neighbours who allegedly played music and sang late into the night has been suspended from the medical register for three months. The Medical Practitioners Tribunal Service also found that Alexander Munro, 67, had not properly examined the 84 year old woman for signs of dementia. The drug could have been fatal had it fallen into the hands of a child, the tribunal heard. (See *The BMJ*'s full story at doi:10.1136/bmj.i921.)

GETTY IMAGES

Psychiatrist is struck off

Adam Osborne (left), a psychiatrist, was struck off the UK medical register after admitting to a sexual relationship with a vulnerable patient. Osborne was treating the patient for depression and anxiety in his private London clinic when the affair began, but she took an overdose when he ended it two years later. The Medical Practitioners Tribunal Service heard that Osborne had asked her at the start of the affair to promise that she would not report him to the General Medical Council (doi:10.1136/bmj.i900).

Tobacco control

Offer tax breaks for safer products

Incentives for the tobacco industry to produce new, low risk nicotine products, including tax breaks, could help to cut smoking, researchers from the universities of Bath, UK, and Ottawa, Canada, said in a report. They argued that progress in reducing the levels of smoking was hampered by the aggressive way in which a few big companies fight to protect profits.

NHS finance

Department of Health gets £205m cash injection

The Treasury was forced to bail out the Department of Health with a £205m cash injection for 2015-16. This increases the department's budget for the year from £98.7bn to £98.9bn. The Treasury blamed the extra funding on the Pharmaceutical Price Regulation Scheme payment for 2015-16 being lower than expected when the budget was set (doi:10.1136/bmj.i879).

Zika virus

Eye damage is linked to Zika virus

A Brazilian study of 29 infants with microcephaly with a presumed diagnosis of congenital Zika virus infection found that a third had vision threatening eye damage (doi:10.1136/bmj.i855).

Research bodies vow to share data

Academic journals, charities, research funders, and institutes

GETTY IMAGES

committed to sharing data and results relevant to the current Zika virus outbreak. The organisations, including Médecins Sans Frontières and the Wellcome Trust, along with *The BMJ*, *Nature*, *Science*, and the *New England Journal of Medicine*, signed a joint declaration and urged other bodies to join them (doi:10.1136/bmj.i855).

Big pharma

GSK is fined for delayed generic manufacture

GlaxoSmithKline, the UK drug company, was fined more than £37.6m for striking deals from 2001 to 2004 to stifle competition from generic drug makers with its antidepressant

MEDICINE

paroxetine. GSK struck agreements to pay more than £50m in cash and value transfers to the generic manufacturers to delay their entry to the UK paroxetine market, the Competition and Markets Authority concluded. The deals "potentially deprived the NHS of the significant price falls that generally result from generic competition," it said (doi:10.1136/bmj.i917).

Research news

Loss of reward motivates workers to exercise

The best way to encourage workers to participate in wellness programmes is not to reward them when they achieve goals but to penalise them when they do not, a study found. A cash reward of about $1.40 (£1) a day or a lottery incentive (where participants could win $5 or $50) were no better than controls for getting people to take 7000 steps a day. But paying staff upfront for a month with the threat of taking it away increased target days by 50% (doi:10.1136/bmj.i932).

PPI use may raise dementia risk

Proton pump inhibitor use may be linked to a higher risk of dementia, a prospective cohort study found. Researchers identified 29 510 people who developed dementia. A total of 2950 were receiving regular proton pump medicine and had a significantly higher risk of incident dementia (hazard ratio 1.44). Randomised studies are needed to establish a direct cause, said the authors (doi:10.1136/bmj.i972).

High cholesterol diet is not bad for heart

A relatively high cholesterol diet and eating eggs regularly are not linked to a higher risk of coronary heart disease events, including myocardial infarction, showed a 20 year follow-up study of men in Finland that included some at increased genetic risk (doi:10.1136/bmj.i919).

Refugee crisis

Australian doctors refuse to discharge refugee girl

Paediatricians at the Lady Cilento Hospital in Brisbane defied the Australian government by refusing to discharge the child of an asylum seeker, saying that she faced unsafe conditions in an offshore immigration detention centre. They said it was their ethical duty not to release the 12 month old, known as Baby Asha, who is recovering from burn injuries sustained while living in a tent in the Australia run immigration detention camp on the remote Pacific island of Nauru (doi:10.1136/bmj.i930).

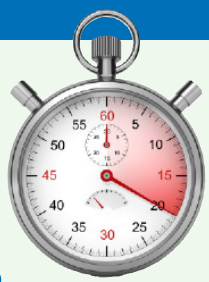
Cite this as: *BMJ* 2016;352:i952

DAN PELED/PA

RISE IN DEATH

Deaths in England and Wales increased by 5.4% in 2015 compared with 2014, the biggest rise for several decades

SIXTY SECONDS ON . . . BED BLOCKERS



NHS MANAGERS ARE WORRIED

They have reason to be. The think tank the King's Fund has reported that what worries them most is missing the four hour target for emergency department patients to be seen and delayed transfers of care.

AREN'T THEY THE SAME THING?

They're strongly related. Both are symptoms of flow problems through the hospital: if you can't move patients through emergency departments because beds are occupied by people whose transfers have been delayed, you're in trouble.

THE DREADED BED BLOCKER PROBLEM ONCE AGAIN?

Yes. In December 2015 NHS hospitals in England had 5009 patients whose transfers of care were delayed, 1140 more than in the same month in 2010. More patients are waiting, and for longer.

WHO'S TO BLAME?

Blame is a cruel word. It's better to explain than to blame, which is why some people think the term bed blocker should be binned.

OK, EXPLAIN THEN

Three types of delay dominate. Patients awaiting a care package in their own home account for more than half the increase in numbers, patients waiting for a nursing home place a quarter, and those waiting for non-acute NHS care the other quarter.

BSIP/ALAMY

IS BED BLOCKING AT A HISTORICAL HIGH?

Depends how you look at it. There were more delayed patients in 2007 than there are today, but the NHS then had 20 000 more acute care beds. As a proportion of available beds, the number now is pretty high: about 5% of beds are occupied by patients who could be discharged. Cure that and you would eliminate the two top worries of NHS managers, giving them time to find something else to worry about.

Nigel Hawkes, London Cite this as: *BMJ* 2016;352:i935

Finalists are announced for The BMJ Awards

The clinical leadership teams that have made the shortlist for The BMJ Awards 2016 cover a range of subjects, including reconfiguring ophthalmology services in Leeds, improving heart health in Bradford, and restructuring diabetes care in Portsmouth to ensure that patients access the right specialist care.

Now in their eighth year, the awards have this year attracted more than 300 entries, from which about 70 have been shortlisted. Four new categories are included in the 2016 awards: anaesthesia, dermatology, neurology, and prevention.

Next month the shortlisted teams will present their projects to a face to face judging panel, which for the first time will include a patient representative. The winners will be announced on 5 May at the Park Plaza Westminster Bridge, London.

Shortlisted teams in the diabetes category cover many areas of disease management, including raising the standard of research into diabetes in pregnancy, improving outcomes in children with diabetes through peer support and engagement with schools, and using technology to improve blood glucose control.

For a list of finalists see thebmjawards.com.

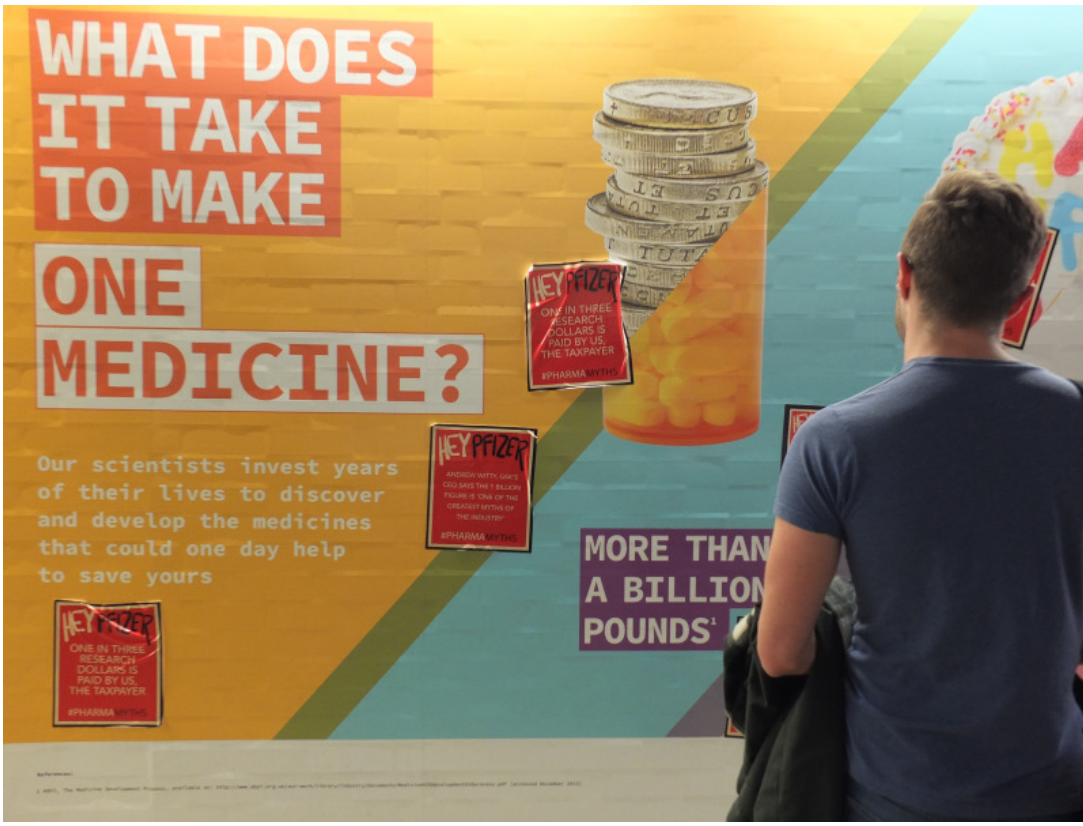
Cite this as: *BMJ* 2016;352:i946

CATEGORIES FOR **THE BMJ AWARDS 2016**

- Anaesthesia Team
- Cancer Care Team
- Cardiology Team
- Clinical Leadership Team
- Dermatology Team
- Diabetes Team
- Education Team
- Gastroenterology Team
- Innovation into Practice Team
- Neurology Team
- Palliative Care Team
- Prevention Team
- Primary Care Team
- UK Research Paper
- Lifetime Achievement Award

MSF accuses Pfizer of misleading public

Role of university research and public money ignored



MARY GALLAGHER/MSF

Treasury will take "incredibly dim view" of estimated £2.3bn NHS overspend

The last time the Department of Health overspent its budget by a small amount in 2005-06... the permanent secretary went

Overspending in the NHS is growing so much that the Department of Health for England risks not being able to find the funds to cover the deficit this year and may breach its expenditure limit, a quarterly monitoring report by the King's Fund warns.

NHS trusts overspent by £1.6bn in the second quarter and were forecast to reach £2.2bn by the end of this financial year, but NHS England wants it contained at £1.8bn. The King's Fund's latest regular survey of finance directors suggested that achieving this is highly unlikely.

Two thirds (67%) of the finance directors expect their organisations to overspend by the end of this year, including 89% of acute trusts. For the first time the finance directors were asked to predict the scale of that overspending, which amounted to £2.3bn when scaled up across the whole of England, acute trusts being responsible for 98%.

While only 18% of finance directors at clinical commission groups predicted that they would end the year having overspent, this is twice the proportion that said at the end of the first quarter that they would do so.

As in previous years, trusts are expected to make efficiency savings of around 4.5% this year, but over the past four years the proportion of finance directors who are worried about meeting their savings targets has been steadily increasing.

In an effort to reduce trust spending the department imposed a cap on agency staff spending, but 53% of finance directors were still fairly or very concerned that they will not contain their agency

The charity Médecins Sans Frontières has accused the drug company Pfizer of using misleading advertisements in an attempt to justify to MPs and the public the high prices it charges for drugs.

The advertisements, displayed at Westminster underground station in London, the nearest stop to parliament, at the beginning of February, claimed that to bring a single drug to market cost more than £1bn and took more than 12 years in research and development and "immeasurable dedication."

MSF slapped posters over the advertisements disputing the claims and highlighting the role of university research and public money.

Manica Balasegaram, executive director of MSF's access to medicines campaign, said that Pfizer was misleading the public and MPs. She said, "Pfizer's claims serve nothing but to highlight our broken research and development system; they claim they spend £1bn on research and development for one medicine, but they don't tell you how they arrived at that figure."

She added, "The reality is that taxpayers foot much of the research and development bill through the funding and hard work that universities and government funded laboratories do in actually discovering the compounds that are turned into blockbuster drugs."

A spokeswoman for Pfizer said that its campaign celebrated the science behind the discovery and development of drugs and vaccines and welcomed an "evidence based" debate on access to medicines.

She said, "We are proud this campaign is helping raise awareness and spark much needed public debate about the important role scientific innovation and the pharmaceutical industry play in helping many of us live longer, healthier lives."

Anne Gulland, London

Cite this as: *BMJ* 2016;352:i896

spending within the set limits.

NHS finance directors recognised that financial stresses are affecting patient care: 53% said that patient care had got worse, the highest since the King's Fund surveys began.

John Appleby, chief economist at the King's Fund, told *The BMJ*: "There must be now a significant worry on the Department of Health's side that they can't cover the overspend by hospitals and providers, in which case they could break the overall departmental expenditure limit, which means the department has overspent its budget," said Appleby.

"The Treasury will take an incredibly dim view of this," he added, "Especially as they have put extra money in this year: £205m in additional funding, and a transfer of £950m from capital to revenue budgets. The last time the Department of Health overspent its budget by a small amount in 2005-06 the incumbent health secretary, Patricia Hewitt, had been in post only a few months and kept her job, but the permanent secretary went."

Ingrid Torjesen, London

Cite this as: *BMJ* 2016;352:i979

NHS PERFORMANCE AGAINST **KEY TARGETS**

- Six week waiting time for diagnostics missed for two years.
- 18 week target was breached for the first time in December 2015.
- Some 3.5 million people are waiting for an operation—the highest since 2008.
- Cancer waits were breached for the past seven quarters.
- Three times more patients in emergency units were not seen within four hours than in 2010.
- Five times more trolley waits occurred than in 2010.
- Hospital bed days lost owing to delayed transfers of care have almost doubled since 2010.

FIVE MINUTES WITH . . .

John Appleby

The chief economist at the King's Fund discusses how to better balance the NHS books

"Jeremy Hunt said in an interview with the *Guardian* on Monday that he thinks there should be more money for the NHS—after 2020 and dependent on the economy growing. Well, that's great, but the economy's growing now and is forecast to continue. All of the evidence is that the pressure has already built up and that more money is needed now.

"Under current plans, healthcare is declining as a percentage of gross domestic product, as is social care spending, so even if the GDP pie is growing we're devoting a smaller chunk of it to health and social care.

"Wealthier countries tend to spend more of their GDP proportionally on healthcare: it becomes a spending of choice as you get richer. But we're going the other way at the moment, bucking that general trend as a country, over time and compared with other countries.

"If health spending just kept pace with the growth of the economy, we could be looking at £10bn to £15bn extra in real terms for the NHS across the United Kingdom from 2015-16 to 2020-21, if not more. That's not an insignificant extra amount, and it would help.

"The economist Kate Barker led a commission for the King's Fund that suggested it was reasonable for the country to devote around 11% of GDP to health and social care combined. In 2013 the UK spent 8.5% of GDP on health.

"So, taking all of this together and given the reasonably low base for spending compared with other countries, it seems reasonable to suggest that, in the short term, more money should be spent. In the longer term, as medical technology moves on, we'll find new, more efficient ways of providing care, but this won't happen overnight.

"The government's macro choice has been to try to pay down the debt and deficit, but also to reduce government spending as a proportion of GDP overall. It's not as though there's a direct switch from public spending towards getting rid of the debt and deficit: it's actually about reducing spending overall. So that's a political choice, but it's always just a choice."

Ingrid Torjesen, London

Cite this as: *BMJ* 2016;352:i965

Physician Lisa Federle examines a refugee (right) with the help of a translator in a mobile doctor's practice in Tübingen, Germany

DPA/PA

Doctors demand free healthcare for refugees in Germany

Voluntary services that have been providing healthcare to refugees in Germany need to be replaced with the medical care to which the country's citizens are entitled, the head of the German Medical Association has said.

Frank Ulrich Montgomery, president of the association, said in a recent video message to members that one of several major challenges facing doctors in Germany in 2016 will be "securing" medical care for refugees. "German doctors with great empathy have succeeded in doing this in recent weeks and months," he said. "The medical care of refugees—measured by the challenge—has functioned."

It was now time, Montgomery said, for proper systems to be put in place to regulate the care of refugees, rather than care being provided voluntarily by doctors. Therefore, the German medical profession was asking for every refugee in Germany to be issued with an electronic health card, he said. The e-health card would entitle the refugee to medical care paid for by public health insurance.

Germany accepted 1.1 million refugees in 2015, and the flow is expected to remain strong in 2016. Currently, refugees in most of Germany's 16 states must get approval from local health or social service officials before visiting a doctor. The refugee e-health card would enable refugees to visit doctors of their choice without first gaining approval. At the moment only four states issue e-health cards to refugees: North Rhine-Westphalia, Bremen, Hamburg, and Schleswig-Holstein.

"[It is] now time for proper systems to be put in place to regulate the care of refugees, rather than care being provided voluntarily by doctors"
– Frank Ulrich Montgomery

Ned Stafford, Hamburg

Cite this as: *BMJ* 2016;352:i884

EDITORIAL

Tackling the crisis in general practice

If general practice fails, the whole NHS fails

A recent editorial in *The BMJ* emphasised the crisis that English hospitals are facing.[1] A £2bn deficit sounds dramatic, but hospitals don't go bust: someone usually picks up the bill. General practice doesn't have that luxury, and its share of the NHS budget has fallen from 11% in 2006 to under 8.5% now.

Recent research shows unprecedented levels of stress among GPs,[2] who now do 60 million consultations a year more than five years ago.[3] A GP's comment at a recent national conference encapsulates the sense of despair: "The pressure of work leaves me in constant fear of making mistakes." GPs are finding it harder to recruit trainees and to find partners to replace those increasingly retiring in their 50s.

NHS England's *Five Year Forward View* presented ambitious plans for moving services into the community.[3] Yet in nearly every year of the past 20 years the number of GPs as a proportion of NHS doctors has fallen. Politicians and NHS leaders argue that more care should be moved into primary care, but funding moves inexorably into hospitals.

General practice has been described as the jewel in the NHS crown.[4] GPs currently manage the great majority of patients without referral or admission to hospital. If this balance shifted only slightly, hospitals would be overwhelmed. The £136 cost per patient per year for unlimited general practice care is less than the cost of a single visit to a hospital outpatient department. Primary care needs fair funding to deliver on the NHS's plans and hospitals need incentives to manage whole populations so that they can't constantly shift work into general practice without resources following.

The £136 cost per patient per year for unlimited general practice care is less than the cost of a single visit to a hospital outpatient department

CORBIS

What are the solutions?

First, general practice needs urgent new funding—like, for example, the £500m rescue package given to emergency departments in 2013. This would enable more staff to be employed to tackle the increasing workload and bureaucracy.

Reviews of practices' contracts that threaten serious financial destabilisation should be put on hold while a fair funding formula is developed to replace the 25 year old Carr-Hill formula.

Support is needed to develop new clinical roles to take the strain off current clinical staff, including medical administrative assistants who could release the equivalent of 1400 extra GPs by doing much of GPs' routine paperwork.[5]

NHS England must tackle spiralling indemnity costs by providing crown indemnity similar to that for hospital doctors, as GPs increasingly do work previously done by specialists. Bureaucracy could be slashed, in part by changing the £224m Care Quality Commission inspection regime to one where only the 5-10% of practices found to be struggling are revisited within five years.

The NHS needs more GPs, through rapid implementation of the agreed "10 point plan,"[6] and more nurses, who face similar problems of recruitment and retention. Medical schools need incentives to produce young doctors who want to be GPs.

In hospitals, consultants' job plans need to change to ensure closer working with primary care.

Choose and Book needs radical reform: we estimate that communicating by phone, email, and online video link could cut outpatient attendance by 50% in some specialties.[7]

Payment by Results must become a population based, capitated budget that incentivises hospitals to support patients and clinicians in the community.

Elephants in the room

Two elephants in the room cannot be ignored. First, cuts to social care make it increasingly hard for hospitals to discharge patients. Second, the UK has fallen well behind its European neighbours—now 13th out of 15 in healthcare expenditure as a percentage of gross domestic product.[8]

Urgent action is needed to restore the NHS. But the crisis will not be averted by focusing on hospitals. If general practice fails, the whole NHS fails.

Cite this as: *BMJ* 2016;352:i942

Find this at: http://dx.doi.org/10.1136/bmj.i942

Martin Roland, professor of health services research, Cambridge Centre For Health Services Research, University of Cambridge
mr108@cam.ac.uk

Sam Everington, chair, Tower Hamlets Clinical Commissioning Group, Mile End Hospital, London

EDITORIAL

Charging migrants for emergency services

The NHS could become the most restrictive healthcare system in Europe for undocumented migrants

The Department of Health is proposing to extend charging for migrants into some NHS primary care services and emergency departments.[1]

Although the government asserts that the NHS is "overly generous to those who have only a temporary relationship with the UK,"[2] these proposals will make the NHS a highly restrictive healthcare system for migrants to access care and treatment.[3 4] Of particular concern is the effect on the thousands of undocumented migrants living without legal status in the UK, who are often marginalised, vulnerable to abuse and exploitation, and have poor health outcomes.[5-7]

This is the third consultation on migrant charging since 2004. The 2013 consultation[2] was framed in the context of restricting services and making the UK a "hostile environment" for undocumented migrants. It was debated alongside the 2014 Immigration Bill, described by the Migrants' Rights Network as "the most draconian challenge to the rights of migrants, and the communities they live in, for a generation."

Phases 1-3 of the 2014-16 implementation plan are projected to recoup £500m (€660; $720). However, the projected savings from changes in the current consultation are only £60.7m over five years, with just £5.7m of that coming from charging in emergency departments.[8]

The proposed extensions to charges will not only recoup much less money but will also be more difficult and potentially dangerous to implement. Furthermore, the estimated savings have been heavily criticised in terms of cost effectiveness, and no cost has been attributed to staff involvement and implementing service changes.[2-7] Government commissioned research has highlighted the challenges to implementation, including the negative effect on access to care and the efficiency of trusts.[9]

Though it may be advantageous to recoup costs from visitors coming from countries with which the UK has reciprocal health agreements, targeting undocumented migrants raises concerns because many of them will be unable to pay.

The more restrictive policies introduced since 2004 discriminate against vulnerable groups (including children and pregnant women, who are not exempt from charging), increase health inequalities, and—importantly—discourage people from seeking timely care and preventive care such as screening and vaccination.[6-10]

This has implications for both individual and public health, leading to increased transmission of infectious diseases, even though treatment will remain free of charge.[6-11] These policies run contrary to other national strategies, including engaging high risk migrant groups in screening for latent tuberculosis.[12]

What Spain and Sweden found

What is alarming in this latest consultation is the commitment to expand charging into emergency services. For many undocumented migrants, the emergency department represents their only source of government funded primary and secondary healthcare. Migrants in the UK already face known barriers to registering with primary care services,[10-14] leaving them few options.

Currently, most other European countries allow undocumented migrants to access free care through emergency departments.[4] In Spain and Sweden, where more restrictive access arrangements were introduced, the governments subsequently reversed the decision because they were unworkable and excluding migrants from healthcare and screening created numerous health risks.

GUSTO IMAGES/SPL

The time has come to question the direction that the UK, and Europe, wants to go on migrant health

Robust research must be done into the cost effectiveness and health implications of expanding charging systems further, before implementation. The government should refrain from making policy decisions to address the NHS's financial problems based on populist reactions, through targeting undocumented migrants for charging, rather than on robust evidence.

One million migrants entered Europe in 2015, and a growing number will continue to travel to the UK with few options to access a basic acceptable level of healthcare under these current proposals. The time has come to question the direction that the UK, and Europe, wants to go on migrant health, and to better define how to fund and deliver effective healthcare to migrants. This must be an evidence based, coordinated, and compassionate response.

Cite this as: *BMJ* 2016;352:i685

Find this at: http://dx.doi.org/10.1136/bmj.i685

Sally Hargreaves, senior research fellow
s.hargreaves@imperial.ac.uk
Laura Nellums, research associate
Jon S Friedland, professor
Jacob Goldberg, research nurse, International Health Unit, Section of Infectious Diseases and Immunity, Department of Medicine, Imperial College London
Philip Murwill, clinic manager,
Lucy Jones, programme manager,
Doctors of the World UK, London

LATEST FREE ZIKA VIRUS RESOURCES FROM BMJ

DPA/PA

All Zika virus material from BMJ is freely avaialable. Visit bmj.com/freezikaresources to access the latest on this global public health emergency. New clinical resources include:

- BMJ Learning module: Mosquito repellents for travellers
- BMJ Best Practice topic about Zika virus
- BMJ patient information leaflet about Zika virus

Latest news from bmj.com/freezikaresources

- CDC updates Zika virus guidance to protect pregnant women
- UK records four case of Zika virus in past six weeks
- Research bodies vow to share data on Zika

LATEST READER RESPONSES

It seems expedient that the public in the UK be made aware of the proportion of this virus. We should not be harbingers of doom; establishing a sense of proportion would be salient here.

Michael Blank, Birmingham

Unless we take rigorous measures to contain the disease there will be catastrophic events with newborn babies. Efforts to create a vaccine must be initiated as soon as possible. Mosquitoes don't differentiate between countries and continents.

Kumari Kusuma, Moodabidri, India

WHO epidemiologists have declared Zika an international global health emergency. Now every mild fever patient will be labelled as having Zika infection, thus raising the incidence to fit the label epidemic /pandemic.

BM Hegde, Mangalore, India

There is an urgent need for "shoe leather epidemiology" in terms of well designed studies with appropriate controls using robust definitions to meet a major gap in confirming, and subsequently quantifying, the link between ZIKA and microcephaly.

Chee Fu Yung, Singapore

Epidemics in areas where the immunological background of the population does not provide herd immunity can give us valuable lessons. We must keep in sight the whole picture and, unless proven otherwise, aim the efforts towards the control of mosquitoes as the main vectors.

Jorge Abelardo Falcon-Lezama, Mexico City

LAST WEEK'S POLL RESULTS:

Is the World Health Organization right to tell women in Zika areas not to delay pregnancy?

Yes 333 votes: 38%

No 534 votes: 62%

THIS WEEK'S POLL:

Should Rio de Janeiro still host the Olympics in light of the Zika virus threat?

ABACA/PA

After the failure of talks over a new junior doctor contract, **Andy Cowper** explores the political landscape of the dispute, **Abi Rimmer** asks doctors what should happen now, and **Gareth Iacobucci** looks at how the imposition of contract changes may play out

Megaphone diplomacy fails

Jeremy Hunt's imposition of a new junior doctors' contract in England, after negotiations failed over pay for Saturday working and a second strike took place, is unlikely to mark the beginning of the end of this dispute. If clinicians and politicians remain as polarised as they are now, this could be only the end of the beginning. Patients, the NHS, and its less politicised clinicians may get stuck in a place of strife.

Both sides leaked to the media throughout, deepening mutual mistrust. Hunt's actions put him firmly in the frame of this dispute: intervening here (and elsewhere) contrary to the 2012 Health and Social Care Act's intended political devolution.

David Dalton's public letter to Hunt, supporting his contract offer and apparently encouraging its imposition, unravelled with embarrassing haste,

Running commentary in the media saw both sides contesting the moral high ground of patient safety

as 14 of its 20 NHS chief executive co-signatories insisted that they did not support imposition of the deal.

Successful negotiators avoid entrenching their positions, enabling give and take. Running commentary in the traditional and social media saw both sides contesting the moral high ground of patient safety. Hunt claimed that studies have shown a "weekend mortality effect," stemming in part from contractual inflexibility—despite a public rebuke from *The BMJ*'s editor in chief that his statements misinterpreted the published data.

Junior doctors, incensed by Hunt's incorrect implication that they didn't work at weekends, outlined risks that clinicians tired by over-rostering would be more prone to error.

POLL TACKS

- A YouGov poll of 1751 adults found broad support for the striking junior doctors. Half (52%) of the sample said that doctors were right to go on strike (32% were against, 17% didn't know).
- On responsibility for the dispute, 12% of respondents blamed the BMA and 45% the government. A third (30%) blamed both sides equally, while 12% didn't know.
- A fifth (22%) said that the government was right to impose the new contract, while 54% said that it was wrong (23% didn't know). Given various options, a majority of 44% agreed that "the government should have continued negotiating with the doctors."
- Offered a range of options of how junior doctors should respond to imposition, 29% thought that juniors should refuse to sign the new contract, while 25% thought they should accept it, and 18% said that junior doctors should continue to protest and take strike action.
- More than half (59%) replied affirmatively to the question, "The government have said that a new deal was necessary in order to expand the level of service offered by the NHS at weekends: generally speaking, do you think that NHS services at the weekend should or should not be expanded in this way?" A fifth (23%) disagreed, and 12% were unsure. The respondents were tied on whether changing the junior doctor contract was necessary to expand weekend services: 35% said that they thought it was and another 35% said that they thought it wasn't, with the rest unsure.

Opinion polls have found sustained public support for the doctors (box): unsurprising, for the most trusted of professions.

Time and money

Why has this fight happened now? One reason is electoral timing. The lack of evident urgency on the part of the BMA's Junior Doctors Committee before the May 2015 general election suggests that they hoped to face a different, more generous administration.

Another is money, out of which the NHS is running at scale and pace. Although Hunt claimed that the Dalton offer was cost neutral, at a 13% uplift to basic pay, many observers were confused that Hunt said likewise when the previously offered uplift was 11%. The big outstanding disagreement—the issue of increased "plain time" (non-overtime) hours on Saturdays—may favour NHS employers, financially and logistically.

Why fight junior doctors? It escapes nobody's attention that negotiations over the consultants' contract remain incomplete. Intent to send a message to all the medical workforce may not be absent from the government's thinking.

More politically engaged junior doctors stiffened their leaders' resolve. →

→ Media briefings reported that the prime minister and chancellor of the exchequer encouraged Hunt to be "deeply muscular" with the BMA. Rugby pitches may be good places for stiff resolve to meet deep muscularity; the field of NHS politics less so.

Both sides' negotiating tactics have been equally wise and strategic—that is, not at all. Privately, NHS leaders veer between hilarity and horror at the intemperate and personalised attacks, particularly once the Dalton offer moved considerably towards dealing with junior doctors' sources of discontent with the 2015 proposals. If junior doctors' leaders had been less entrenched and politically and strategically smarter, Dalton's concessions could have been sold as a success.

Another worrying possibility is that Hunt and junior doctors' leaders are enjoying the "power trip" of the dispute. It's a small step from posing in negotiations to imposing a contract, but a deeply damaging one.

Compromised options

What next? The BMA's Junior Doctors Committee issues belligerent noises. Dalton states that they were "not serious about reaching a compromise."

There is no alternative workforce of junior doctors waiting to step in. Alienating an in-demand group of highly and expensively trained staff who are (mostly) at an unusually mobile point in their lives may prove unwise. The market for healthcare staff is global.

Hunt's term as the 2010-15 coalition government's health secretary blended one part admirable concern for patient safety, one part aforementioned interventionist tendency, evident in his weekly (sometimes twice weekly) meetings with NHS system leaders and phone calls to NHS providers that missed targets, and one part acclaim for not being his predecessor, Andrew Lansley, architect of the Health and Social Care Act.

David Cameron's loyalty to his former boss Lansley blinded him to the chaotic scale and unpopularity of the 2012 act's technocratic reorganisation. The prime minister may not be a details man, but he has rarely made exactly the same mistake twice.

The clock may already be ticking to see who next wins acclaim for not being his or her predecessor.

Andy Cowper, editor, *Health Policy Insight*

Cite this as: *BMJ* 2016;352:i961

Doctors consider their next move

As the government and NHS Employers take forward plans to impose a new junior doctor contract in England, **Abi Rimmer** asks doctors what they think the profession should do now

Junior doctors protest outside the Department of Health on 11 February 2016

The BMA's Junior Doctors Committee will discuss how it plans to pursue its opposition to plans to impose a new contract on junior doctors at a meeting on 20 February. Johann Malawana, chair of the committee, has said that feedback from meetings with junior doctors would "shape the 'what next' for the BMA."

When the imposition was first announced, Malawana said that further action was "inevitable." Among junior doctors there is support for this view. Janis Burns, a trainee anaesthetist, hopes that the BMA will consult its members and take action that is "far more hard hitting than industrial action to date." She added, "Imposition is a dictatorial move and cannot be met with mediocre action, however regrettable that may be."

Steven Alderson, a second year core trainee in acute care common stem anaesthetics, said that the BMA needs to decide what its new aims are and how far the profession is prepared to go. "Given the anger, I wouldn't be surprised at further industrial action, perhaps aimed at securing concessions around some of the smaller-print issues—like the right of employers to 'first refusal' on locum work, or non-resident on-call working," he said. "Similarly, I'd anticipate a willingness from the Department of Health to make the bitter pill of an imposed contract easier to swallow."

Others are keen for the government to return to negotiations. "Ultimately I think we need to re-evaluate the reasons why we looked at developing a new contract," said Benjamin Fox, chair of the anaesthetists in training group at the Association of Anaesthetists of Great Britain and Ireland. "Perhaps now is not the right time to negotiate and we should instead pause on contract reform."

Aoife Abbey, a third year specialist trainee in anaesthesia, said that the next steps should focus on the specific problems of the new contract. "The time for overly generic statements like 'not fair, not safe' has passed," she

Five health secretaries who didn't "battle" with doctors

Jeremy Hunt has said that "battles" with doctors come with the territory of being health secretary, citing Nye Bevan, Ken Clarke, Norman Fowler, and Patricia Hewitt to illustrate his point. Here are five counterexamples

STEPHEN DORRELL
(Conservative, 1995 to 1997)
Dorrell was respected for engaging with doctors and listening to their concerns. He helped to resolve problems with GP out-of-hours services.

FRANK DOBSON
(Labour, 1997 to 1999)
Dobson was popular with doctors and regarded as a defender of the NHS, in the mould of Nye Bevan. He resigned as health secretary to run for mayor of London.

DAN KITWOOD/GETTY IMAGES

said. "The real challenge in the short term is to rise above our anguish."

Royal college response

Medical royal colleges have also pushed for the government to reconsider its position. The Royal College of Paediatrics and Child Health has written to Hunt "asking that government reflects upon the impact of their decision upon the NHS and urge them to reconsider." A spokeswoman said, "This action will add further pressure to an already strained workforce."

Helgi Johannsson, an anaesthesia consultant, said that the new contract would be a major blow to junior doctors' morale and could force trainees to leave. "In anaesthesia we already have a large number of vacancies," he said. "There is no end in sight for this, and our training school advises us that the situation will only get worse."

Partha Kar, a diabetes and endocrinology consultant, is also

COMMENT
See Margaret McCartney, p 273 and David Oliver, p 277

worried about the contract's affect on morale. "If even a fraction of juniors go to other places, the rota gaps would genuinely start to worry me. I am not a fan of shroud waving, but this time I am worried."

He added, "As regards the profession, it could spell further trouble down the line with consultant contracts and GP contracts yet to be resolved. Vocation comes from those who are happy and engaged. We all recognise how much the goodwill makes the NHS run, especially from junior docs."

Megan Joyce, a second year foundation trainee, said that the government's failure to recognise the altruism in the profession "has had a massive impact on how doctors see Hunt."

"People can accept, in the short term, working extra hours and even not being recognised, so long as they see patients benefit," she said. "What people cannot accept is Hunt and the media saying that doctors are not working, when they are. I think that if Hunt had approached the negotiations as junior doctors have, with the hope of improving an out of date contract so that it is fit for purpose in current times, then there would have been a much better outcome for the NHS."

Abi Rimmer, BMJ Careers
arimmer@bmj.com

ALAN MILBURN
(Labour, 1999 to 2003)
Milburn was the prime mover behind the NHS Plan in 2000. He was supportive during the negotiation of the new GP contract. In 2002 Milburn introduced foundation trusts.

JOHN REID
(Labour, 2003 to 2005)
Reid was thought to have a good relationship with the profession. He was criticised for giving GPs a 22% pay rise, while allowing them to opt out of weekend and evening work.

ALAN JOHNSON
(Labour, 2007 to 2009)
Johnson was regarded as somone who listened to doctors and tried to work with them rather than steamroll policies through.

The key questions

What will the government and BMA do now?
The government and NHS Employers have set out a timetable for a phased implementation of the new contract for junior doctors in England over 12 months from August 2016. But the BMA has vowed to fight on in defiance of the imposition and is considering what action to take next. The chair of the BMA's Junior Doctors' Committee, Johann Malawana, said that further action was "inevitable" after the BMA received "a tidal wave of calls" on the health secretary Jeremy Hunt's announcement that he would push through a deal. The Junior Doctors Committee is meeting on 20 February to decide its next move. This could include a legal challenge, as experts have indicated that the government's imposition could be in contravention of European Union law.

Do NHS trusts have to impose the contract?
The Department of Health has confirmed that England's 152 foundation trusts, which are semi-autonomous, have the freedom to ignore the government's imposition and will be able to negotiate contracts locally. But all 86 non-foundation trusts will be obliged to adopt the government's national contract as stipulated. Some leaders of trusts with and without foundation status have said that they do not support an imposition of Hunt's contract.

What else might doctors do?
The BMA says that nothing is off the table as it considers its options. In addition to a possible legal challenge, doctors have said that further industrial action—working to rule, and even mass resignation—may be up for consideration. On the resignation point, the former Labour party health adviser Jon McTernan said that junior doctors could take the radical step of setting up an agency that could provide services back to the NHS, which would enable them to resign en masse and join the agency rather than accept the new contract. "Then the BMA could sell services back to the NHS on the terms it wants," he said.

Will doctors leave the NHS?
The government has been warned that the imposition of a new deal will mean an increasing number of junior doctors leaving England to work in countries such as Australia and New Zealand. Despite pressures on working conditions, the number of UK doctors choosing to work in antipodean climes has changed little in recent years. But the imposition could be a tipping point for some. There is also the risk of junior doctors in England leaving to work in Wales and Scotland, where the unpopular new contract will not be imposed. The Scottish and Welsh governments are actively seeking to recruit doctors from England.

Gareth Iacobucci, *The BMJ*
giacobucci@bmj.com

“CLICK HERE TO SEE A DOCTOR”

Technology is bringing consultations back into the home. **Nigel Hawkes** reports below on a global trend for app happy doctors to adopt the Uber model to market services via a smartphone. **Ingrid Torjesen** looks at the rise of private companies offering virtual access to GPs for a fee, a model that finds no favour with the profession’s leaders

Uber for healthcare

It’s ridiculously inefficient and very, very few doctors will actually want this kind of life, but it was ridiculously fun
–Jay Parkinson, Brooklyn, New York

Is it time to reinvent the home visit? In the NHS they have been in steady decline for decades and now account for fewer than one in 25 general practitioner consultations. In the US the rate of house calls is even lower—around one in every 100 consultations—but app happy entrepreneurs backed by venture capitalists believe that they can turn back the clock.

The past two years have seen the emergence of several small companies claiming to be “the Uber of healthcare.” Just as impatient urbanites can summon a taxi via the Uber app on their smartphone, worried parents can now call a doctor to treat their child’s earache, and office workers can order a flu jab at their desk as readily as a pizza.

“Everything a primary care doctor can do we can do,” says Renee Dua, a kidney specialist and founder of Heal, a west coast start-up company that has treated 2000 patients since its launch a year ago in Los Angeles and Orange County, California. She and her husband started the service after struggling to get a paediatric appointment for their son and spending a miserable evening in the emergency room.

Heal operates daily from 8 am to 8 pm, and for a flat fee of $99 (£68; €88) will dispatch a doctor to arrive at your door within 60 minutes.

Keep it flexible

Dua herself spends time making house calls, and loves it. “Yesterday I spent the morning seeing my nephrology patients and the afternoon doing house calls,” she tells *The BMJ*. “In an office practice there’s a lot of responsibilities: you have employees, you have scheduling, you have insurance, you have to deal with the costs of running a business.

“With Heal you’re given a medical assistant who carries your supplies. You have no office, we pay for your staff, we handle your malpractice. Your sole objective is to show up and focus on that patient. The medical assistant can even act as your scribe. The average Heal visit is 25 minutes long, while the average appointment in the US lasts 10 minutes.

“You can schedule your time according to your needs. If you need to be home by 3 pm to pick up the kids from school, we can fit in with that. So there’s a lot more flexibility and a lot more autonomy and independence, and that’s what all doctors want.”

Pager, based in New York and San Francisco, has a similar business model, offering a first visit for $50, rising to $200 for subsequent ones. It has launched a “Pager for Business” service that provides visits to offices, for which employees pay just $25. Others with the same idea include MedZed in Atlanta, Dispatch Health in Denver, and Retrace Health in Minneapolis. Even Uber has dipped a toe in the water, offering at-home flu vaccinations this winter in 35 US cities for a bargain $10—but only on a single day.

Outside the United States, a Portuguese company called Knok seems to be leading the way. “Knok, Knok…the doctor knocks at your door” it wittily introduces itself on its website. Using a map and GPS, users can select an available doctor nearby and ask him or her to call. Payment—from €60 to €100—is made through the app, which also includes feedback from other users. Founder, Jose Bastos, told the Lisbon daily *Publico* that he has so far enlisted 50 doctors, with 70 more expressing an interest. He believes it is the only such service in Europe.[2]

Dua says she thought it might be difficult to recruit doctors, but the fear proved groundless. “We have doctors coming to us—we now have a waiting list. We have family practitioners, internists, and paediatricians, and we do have a fair numbers of specialists who have come to us saying my specialty can be done in the home—rheumatologists, for example.”

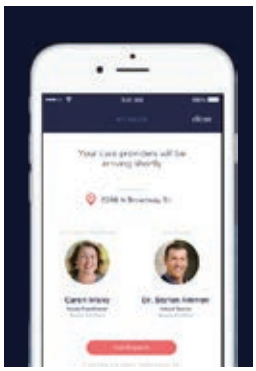
Can it work?

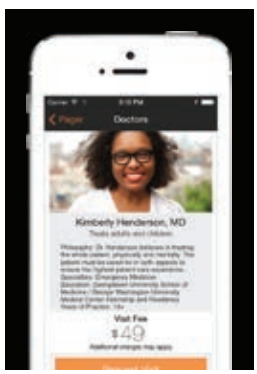
In the UK, where people are unused to paying cash for healthcare, it might be a stretch. And Jay Parkinson, a New York doctor who launched a singlehanded iPhone based practice in Brooklyn at the dawn of the app age in 2007, doubts it has a future there either. It worked, but he flogged himself to death, schlepping through New York’s cold and snow every day, as he puts it, to see seven or eight patients when an office based doctor can see 30. “It’s ridiculously inefficient and very, very few doctors will actually want this kind of life,” he concluded. “But it was ridiculously fun.” His has now colaunched Sherpaa, a company that provides consultations online.[3]

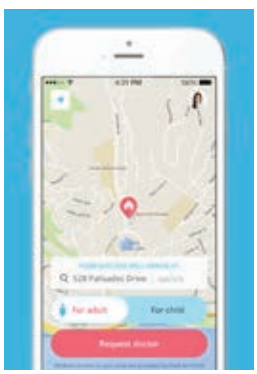
But Dua has no doubts. “The business in California is doing well,” she says. “We intend to perfect the model here and then expand nationwide, and worldwide.”

Nigel Hawkes, freelance journalist, London, UK

Cite this as: *BMJ* 2016;352:i771
Find this at: http://dx.doi.org/10.1136/bmj.i771







The private, online GP will see you now

Increasing numbers of general practitioners now offer virtual consultations. And several private companies, such as Dr Now, Dr Morton's, and Babylon, offer patients remote consultations for a fee, using computers, tablets, telephones, or smartphones.

Services provided by these companies vary but can include private drug prescriptions delivered to your door, diagnostic tests by post, and medical monitoring. Patients can access records related to their consultation through the companies' websites. They either pay for a one-off consultation or pay a monthly subscription for access on demand. And companies are expanding to offer services to employers—and through the NHS.

Karen Morton, a gynaecologist and obstetrician, launched Dr Morton's with John Wilkes, its chief executive, in April 2015.

"More and more of my patients were having trouble getting appointments with their GP," she says. "A new type of health consumer is growing in the UK who is prepared to pay relatively small amounts of money for their healthcare."

Wilkes estimates that up to 70% of general practice patients do not need to attend a surgery and that time taken off work to see a GP has net cost to the British economy of £5bn (€6.5bn; $7bn).

Dr Now's website includes a calculator to show businesses the potential cost savings of staff not taking time off to see a GP. It also targets clinical commissioning groups. Dr Morton's has been approached by NHS GPs looking for support, Morton says, but has decided against it because of the funding model. "NHS purchasing procedures tend to favour large established companies rather than the smaller new technology providers," she says.

Private GPs for the NHS

One company already partners the NHS, however. Babylon, launched in 2014 by Ali Parsa, who set up Circle, the private company that ran Hinchingbrooke Hospital for the NHS, provides services to NHS patients at two practices in Essex in a pilot scheme funded by NHS England.

Paul Husselbee, a partner at one of the practices, Highlands Surgery in Leigh-on-Sea, told *The BMJ*, "The idea is that at times of demand patients always have access to a doctor and do not need to use A&E [emergency departments]. It also frees up GP time from dealing with the more straightforward problems."

Highlands' patients can consult a Babylon GP six days a week, from 8 am till 8 pm, using a smartphone app. Patient satisfaction is high, and in four months waiting times for routine appointments had gone down by a week, Husselbee said. However, these services do not have access to patients' full medical notes.

Maureen Baker, chair of the Royal College of General Practitioners, told *The BMJ*, "Private companies offering access to GPs for a fee are not the solution to the intense pressures facing general practice or for our patients who are finding it difficult to make an appointment.

"We have concerns about the patient safety implications of private companies offering virtual consultations to patients with GPs who are unfamiliar with, and won't necessarily have access to their medical history or information about drugs that they have been prescribed. There are also many signs and symptoms that GPs look out for when making a diagnosis that the patient might not think to raise."

Parsa says that Babylon will soon partner one of the largest GP partnerships in the country. But unlike in the pilot, the partnership's own GPs would use Babylon's technology.

The way that patients see doctors has hardly changed from the 18th century, Parsa says.

Ingrid Torjesen, freelance journalist, London, UK

Cite this as: *BMJ* 2016;352:i823

Find this at: http://dx.doi.org/10.1136/bmj.i823

We have concerns about the patient safety implications of private companies offering virtual consultations to patients with GPs who are unfamiliar with their medical history
–Maureen Baker

PETER LOCKE

Ian Forgacs got a gut feeling in his second term at medical school. So compelling was his love affair with the GI tract that he seems to have paid most other systems only sufficient attention to satisfy his examiners. Today he is consultant gastroenterologist at King's College Hospital and president of the British Society of Gastroenterology. He enjoyed many years on the editorial committees of *The BMJ* and *Gut* and has more recently been at the forefront of improving training programmes in his specialty—transforming them from the days when he was shown a scope and an orifice and told to get on with it.

BMJ CONFIDENTIAL

Ian Forgacs
Loves skinny dipping

What was your earliest ambition?
To play football for England.

Who has been your biggest inspiration?
I spent my student elective with Howard Spiro, chief of gastroenterology at Yale School of Medicine. He taught me so much, but especially that listening to patients and hearing what they were saying were very different things.

What was the worst mistake in your career?
As house officer to the senior surgeon at Guy's, I managed to suture the great man's glove to an inguinal ligament on the sole occasion he decided that I'd do the operation and he'd assist.

What was your best career move?
Choosing medicine over surgery.

Bevan or Lansley? Who has been the best and the worst health secretary in your lifetime?
The BMJ's editor in the 1940s fiercely opposed the creation of the NHS, but after Nye Bevan died in 1960 he expressed the sentiment—true to this day—that Bevan had been "the most brilliant minister of health this country has ever had." The present incumbent could learn so much from the manner in which Bevan engaged and negotiated with medical leaders.

Who is the person you would most like to thank, and why?
Wolfgang Amadeus Mozart, for delivering the full range of emotional experience in 626 works of unparalleled musical genius.

Where are or were you happiest?
Inside Wembley Stadium just after 5.15 pm on Saturday 30 July 1966.

What single unheralded change has made the most difference in your field?
Every gastroenterologist owes a massive debt to the unsung Harold Hopkins, of the University of Reading, who invented the fibreoptic scope in 1954.

Do you support doctor assisted suicide?
I can't find a moral position that accepts that a doctor should ever take a life.

What book should every doctor read?
Essays, by Montaigne. Although he died in 1592, it contains more that is useful about human beings than can be found in any medical text.

What is your guiltiest pleasure?
Skinny dipping.

What personal ambition do you still have?
That the British Society of Gastroenterology has done all that it can to ensure that every UK patient presenting with acute upper GI bleeding has access to interventional endoscopy within two hours.

What would be on the menu for your last supper?
A dozen large pan seared scallops, butternut squash purée, black truffle cream sauce, and a large glass (dammit, just leave the bottle) of Krug 1998.

If you weren't in your present position what would you be doing instead?
Don't tell Fiona Godlee . . . but maybe editing *The BMJ*.

Cite this as: *BMJ* 2016;352:i171