this week

COUNTING HOSPITAL BEDS page 339 • **REALISTIC MEDICINE** page 340

Staff cuts threaten medical education

Plans to cut staff at Health Education England could damage the care of patients and affect the number of doctors in training, trade unions have warned.

On 23 February HEE, which is responsible for medical education and training in England, wrote to all its 2614 staff announcing a scheme to allow them to take voluntary redundancy to save money.

In 2014 the Department of Health for England said that it was cutting HEE's budget, which ran to £4.9bn in 2015-16, by 20% by 2020. The move was a result of a 20% cut to the department's own budget and is on top of the £22bn efficiency savings being demanded of the NHS.

In response, HEE announced that it was consulting on changes designed to ensure its sustainability, reduce its senior staffing bill, and cut its running costs.

An email sent to staff said that, though the voluntary redundancy scheme was open to everyone, staff members did not have an automatic right to voluntary redundancy. It said that it would have to consider various factors when approving applications for voluntary redundancy, such as "the requirement to retain qualifications, skills, and experience which are essential to HEE."

Nick Bradley, national health officer for Unison, the trade union that represents HEE staff, warned that cuts could affect patient care. "Unison utterly opposes further cuts to NHS services, although we support any voluntary redundancy scheme that allows staff to leave on their own terms," he said. "But there's now a real danger the organisation won't have enough resources to coordinate workforce planning and education properly across the NHS, threatening a lower standard of patient care."

Krishna Kasaraneni, the BMA's lead on GP education, training, and workforce, warned, "From a general practice point of view it will be the end of general practice training as we know it."

Ian Cumming, chief executive of HEE, said, "HEE and our trade union partners are committed to avoiding compulsory redundancies wherever possible. We are committed to using a voluntary approach. It therefore makes sense to run this scheme now, as all of the savings that accrue will in turn reduce the total amount required from the wider changes currently being planned for the 2017-18 financial year."

Abi Rimmer, BMJ Careers

Cite this as: *BMJ* 2017;356:j1069

Savings made now will reduce the amount required from wider changes next year, said Ian Cumming, HEE chief executive

LATEST ONLINE

- Complications are more common in young people with type 2 diabetes than with type 1
- Court overturns first case based on ruling that patients have right to information on all treatment options
- Non-invasive prenatal screening should be banned for sex selection, says ethics report

SEVEN DAYS IN

Meg Hillier, chair of the committee, said: "Few trusts feel they have a credible plan for meeting the financial targets that have been set by the government."

MPs call for end to "bickering" over NHS funding

An influential committee of MPs has urged the government to stop "bickering in public" with NHS leaders over the funding of the health service in England and provide an honest assessment of how current financial pressures are affecting the care of patients.

In a report the House of Commons Committee of Public Accounts said that public disagreements between ministers and NHS England were damaging at a time when solutions were needed to tackle the severe and unsustainable financial strain facing the NHS.

Tensions between the government and NHS leaders have risen in recent months after the repeated insistence from the prime minister and health secretary that the NHS had received more money than it asked for, a claim that NHS England's chief executive, Simon Stevens, robustly disputed when giving evidence to the committee.

In its report, the committee urged the Department of Health, NHS England, and Number 10 to work together to set "clear and transparent" recovery plans by next month to support local NHS bodies and health economies in severe financial difficulty. It also asked the health department and NHS England to report back to the committee by July 2017 on what they had done to understand the association between financial performance and patient care.

Gareth Iacobucci, *The BMJ* Cite this as: *BMJ* 2017;356:j1014

Research news

Bleeding near brain is linked to anti-clotting drugs

Antithrombotic drug use, particularly vitamin K antagonists, may increase the risk of subdural haematoma, a study in *JAMA* showed. Data on 10 010 patients with a first ever subdural haematoma showed that low dose aspirin was associated with a small increased risk of subdural haematoma (adjusted odds ratio 1.24 (95% confidence interval 1.15 to 1.33)); clopidogrel and a direct oral anticoagulant were associated with a moderately higher risk (1.87 (1.57 to 2.24) and 1.73 (1.31 to 2.28), respectively); and a vitamin K antagonist, such as warfarin, was associated with a much higher risk (3.69 (3.38 to 4.03)). (doi:10.1136/bmj.j1044)

NHS finances

Moving care out of hospital is unlikely to save money

A review of 27 initiatives in England designed to move care out of hospital found that the policy is unlikely to save the NHS money but could improve patient care. The concept underpins the NHS's 44 sustainability and transformation plans, which aim to help the NHS make £22bn of efficiency savings by 2020-21. But the Nuffield Trust concluded that some plans were working to "undeliverable expectations" about the economic benefits of shifting more care into the community and would struggle to reduce the number of patients requiring hospital treatment without additional money and staff. (doi:10.1136/bmj.j1046)

Diet

"Five a day" may help to keep dementia away

Having at least three servings of vegetables and two servings of fruit a day may help prevent dementia in older adults, a study published in *Age and Ageing* found. The cognitive status of 17 700 dementia-free older adults was followed over six years. The researchers found that those consuming at least three daily servings of vegetables and two of fruit, as recommended by the World Health Organization, had lower odds of developing dementia (odds ratio 0.7 (95% confidence interval 0.60 to 0.95); P=0.02).

Ten portions are better than five, finds analysis

Eating five a day reduces the chance of heart attack, stroke, cancer, and early death, but the greatest benefit comes from eating 10 portions a day, showed a meta-analysis of 95 studies including almost two million people, published in the *International Journal of Epidemiology*. Eating 10 portions was associated with a 24% lower risk of heart disease, a 33% reduced risk of stroke, a 28% reduced risk of cardiovascular disease, a 13% reduced risk of total cancer, and a 31% reduced risk of dying prematurely.

Rare diseases

"Disjointed" approach still fails patients

Many patients with rare diseases are still not receiving the right treatment in England despite a UK strategy being launched to improve care more than three years ago, MPs and peers said. Departments of health in Scotland, Wales, and Northern Ireland have all developed plans to implement the strategy but not England, where some people with rare diseases are struggling to access treatment and information about their condition and do not feel involved in decisions about their care, a report found. (doi:10.1136/bmj.j1037)

Emergency care

NHS 111 sends more callers to A&E

The number of people calling 111 and advised to go to their emergency unit or had an ambulance sent has increased from around 150 000 a month to over 200 000 a month over the three years since the service started in late 2013. The Nuffield Trust found that 20-22% of callers were sent an ambulance or advised to go to A&E, up from 18-19% in the early period of the service, which translates to an extra 20 000 people a month.

Organ donation

Most people support "soft" opt-out in UK

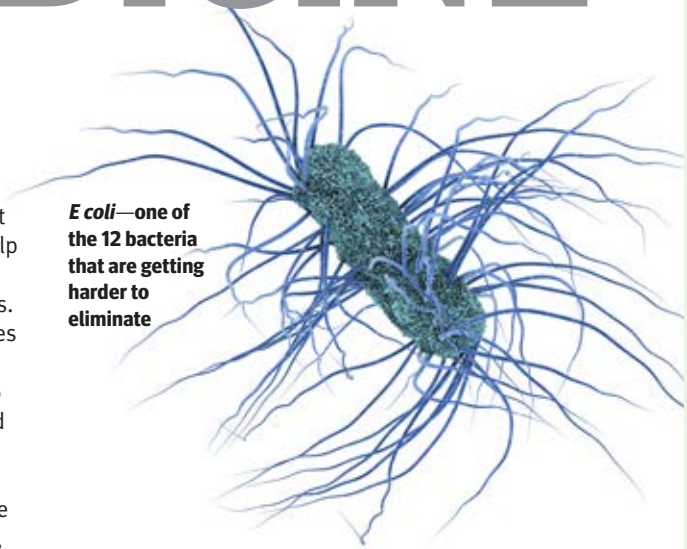
Two thirds (65%) of people in the UK support "soft" opt-out organ donation, a BMA poll of more than 2000 people suggested. It also found that 66% wanted to donate their organs at death but that only 39% were signed up to the organ donation register. England, Northern Ireland, and Scotland have an opt-out system, while Wales has already introduced a "soft" opt-out system, allowing relatives to confirm whether the deceased had an unregistered objection before any procedure goes ahead (see p 359).

MEDICINE

Antibiotics

WHO lists 12 most threatening bacteria

WHO published its first list of "priority pathogens"—12 bacteria that pose the greatest threat to human health—to help guide and promote research and to develop new antibiotics. The most critical group includes multidrug resistant bacteria that pose a particular threat to hospitals, nursing homes, and patients who require devices such as ventilators and blood catheters. The bacteria include *Acinetobacter*, *Pseudomonas*, and various Enterobacteriaceae (including *Klebsiella*, *Escherichia coli*, *Serratia*, and *Proteus*). They have become resistant to many antibiotics, including carbapenems and third generation cephalosporins.



***E coli*—one of the 12 bacteria that are getting harder to eliminate**

NICE

Genetic test is urged in colorectal cancer

Anyone with a colorectal cancer diagnosis should be tested for the inherited genetic condition Lynch syndrome, says guidance from NICE. Testing for the condition will help identify family members also at increased risk of bowel or other cancers associated with the condition (womb, ovarian, and stomach cancer) so that they can be monitored more closely. Lynch syndrome accounts for about 3.3% of colorectal tumours in the UK. Around 175 000 people are thought to have the syndrome in the UK, and most are unaware.

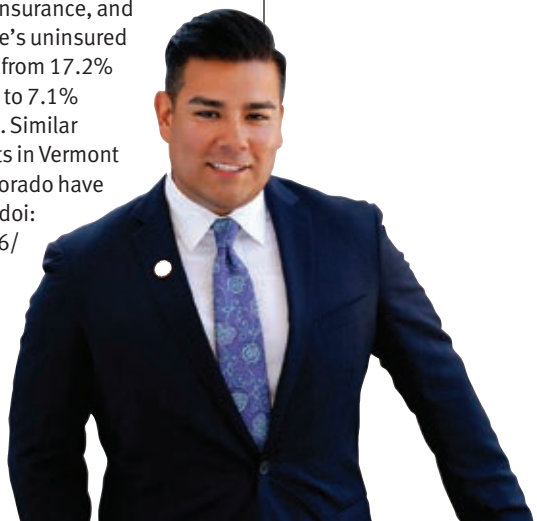
Venues should help prevent drug misuse

Gyms, nightclubs, and festivals should consider providing information about drug use and local support services through social media campaigns, leaflets, or other materials, for people who use drugs or are at risk of doing so, says a NICE guideline. Around one in 12 adults aged 16-59 in England and Wales had taken an illicit drug in 2015-16, and data from 2014 showed that one in 10 schoolchildren had taken drugs in the past year.

US

California plans universal single healthcare system

Two California state senators, Ricardo Lara, below (Democrat, Los Angeles County) and Toni G Atkins (Democrat, San Diego), introduced legislation to establish a universal, single payer healthcare insurance programme that would cover all of the state's residents—including immigrants without documentation—in response to moves by President Donald Trump to repeal the Affordable Care Act. Under the act about five million California residents were able to obtain health insurance, and the state's uninsured rate fell from 17.2% in 2013 to 7.1% in 2016. Similar attempts in Vermont and Colorado have failed. (doi: 10.1136/bmj.j1027)



BREAST CANCER

screening coverage in England increased for the first time since 2011, as **75.5%** of eligible women aged 53-70 recorded a result within the past three years at March 2016 (NHS Digital)

Cite this as: *BMJ* 2017; 356:j1057

SIXTY SECONDS ON . . . HOSPITAL BED NUMBERS

UP OR DOWN?

Both. The number of hospital beds (101 386) in the NHS in England is down this year, but that's because two trusts didn't submit data. Correct for that, and there are around 700 more beds this winter than last. However, over a decade the number fell by a fifth to 2.4 per 1000 population in 2015, the second lowest number in Europe, the BMA says.

IS THAT GOOD OR BAD?

The NHS has led the way in reducing length of stay in hospital, which has been the object of health policy for decades, and this might also reduce the need for beds. But an ageing population means that demand for beds is ever increasing.

DOESN'T CARE SUFFER IF THERE AREN'T ENOUGH BEDS?

The evidence indicates that quality of care diminishes above a target occupancy rate of 85%. Crowded hospitals mean longer waits in emergency departments and a greater risk of infection, as well as more shifting of patients from ward to ward.

THE NUFFIELD TRUST AND THE BMA SAY MANY TRUSTS HAVE OCCUPANCY RATES OF 95% OR OVER

They do, in the peak weeks of the year in the busiest hospitals, as NHS England's bulletins show. But picking a few days of intense demand and generalising from them may not be the best way of finding the truth. NHS England data show that average occupancy of beds that were available overnight in the three months to 31 December 2016 was 88.3%, against 87.5% the year before.

YOU TALK ABOUT BEDS AVAILABLE OVERNIGHT—ARE THERE OTHERS?

Beds available overnight is the key statistic, but there are also more than 12 000 beds available only by day, reflecting the increase in patients who don't need to stay overnight. This number is steadily increasing, and it's double what it was 20 years ago. Funny that these beds don't get as much mention, and of course we don't count the trolleys that sometimes masquerade as beds.

Nigel Hawkes, London

Cite this as: *BMJ* 2017;356:j1011

DOCTORS IN THE NEWS

NHS ENGLAND DIRECTOR ARRESTED ON SUSPICION OF VOYEURISM

Jonathan Fielden, NHS England's deputy medical director and director of specialised commissioning services, has been arrested by police on suspicion of voyeurism.

Formerly a medical director of University College Hospital London NHS Foundation Trust, he is a consultant anaesthetist and intensive care specialist by background.

Fielden, 53, is banned from contact with patients under conditions imposed on an interim basis in January by the Medical Practitioners Tribunal Service, pending a full hearing. He took up leave from his £224 999 job at NHS England in January.

A spokeswoman for Bedfordshire Police said, "A 53 year old man from Biddenham has been arrested on suspicion of voyeurism and has been bailed until 23 March while inquiries continue."

Cite this as: *BMJ* 2017;356:j997

JUNIOR DOCTOR WHO FABRICATED RESEARCH DATA IS REINSTATED

A junior doctor who narrowly escaped being struck off the UK medical register after fabricating research data and citing senior colleagues as coauthors without their knowledge has been allowed to resume practice after a 12 month suspension.

Gemina Doolub, 31, who qualified at Newcastle University in 2009, was working at Oxford University Hospitals NHS Trust in 2013 when she submitted a paper to *ISRN Cardiology* and a research abstract to the *Journal of the American College of Cardiology*. In the paper she named Erica Dall'Armellina, a clinical research fellow at John Radcliffe Hospital in Oxford, as a coauthor without informing her. A month later she submitted the abstract, falsely citing Colin Forfar, a consultant cardiologist at Oxford University Hospitals, as coauthor.

Cite this as: *BMJ* 2017;356:j989

TEXAS NEUROSURGEON GETS LIFE FOR DELIBERATELY INJURING PATIENT

A Texas neurosurgeon accused of deliberately botching spinal operations and leaving a trail of maimed patients has been sentenced to life behind bars, the first US doctor known to have been imprisoned for acts committed in the course of surgery.

Christopher Duntsch, 46, was initially charged with five counts of aggravated assault causing serious bodily injury and one count of injuring an elderly person, but the trial focused on the last charge alone, which alleged that Duntsch deliberately harmed Mary Efurd, then aged 72, in a 2012 operation that left her wheelchair-bound.

Prosecutor Michelle Shughart said that debt, part of which came from malpractice suits in Tennessee, kept Duntsch working.

Cite this as: *BMJ* 2017;356:j994

Clare Dyer, *The BMJ*

Jeremy Hunt: summoned by MPs

Hundreds of cases under review after letters were left in storage

Patient care and safety could easily have been compromised by a "serious" failing of a government agency to send important medical records onwards, it has emerged.

Large amounts of data on patients, including test results and diagnoses, were mistakenly put in storage between 2011 and 2016 by the NHS Shared Business Services agency before the mix up was discovered last year. Most correspondence has now been delivered to hospitals and GP surgeries "wherever possible," NHS England has said.

Details of the scale of the error emerged this week after the *Guardian* newspaper obtained documents showing that around 708 000 pieces of correspondence were undelivered over this period, though 200 000 of these were not clinically relevant.

The data, which included copies of test or screening results and communications about planned treatment, were mistakenly kept in storage. The documentation was sent by hospitals and other GPs to practices in cases where the patient had moved away or was unknown so needed to be redirected.

NHS England said that it had identified around 2500 "pieces of correspondence" whose retention meant potential risk of harm to patients and needed further investigation. So far no evidence of harm has been confirmed.

But information provided by the

Be open and honest with patients, says Scotland's CMO

Attempts are being made in Scotland to empower patients to question their treatment options as the concept of "realistic medicine" is rolled out across the country.

It is based on the idea that overtreatment can lead to harm for patients and waste for the health service when more "realistic" options could produce better results.

Scotland's chief medical officer, Catherine Calderwood (right), introduced the concept in her first annual report last year, resulting in a reception that she says was "universally positive," producing some 10 million tweets on Twitter.

She has followed this up in her second annual report with a set of plans to put the ideas into practice (see box), some of which are already happening. Posters are on display in outpatient clinics in NHS Borders encouraging patients to ask questions of doctors and nurses. This includes asking if the treatment is really needed and what the benefits and risks are. If the poster proves a success, Calderwood hopes to see it introduced across Scotland.

"Realistic medicine puts the person receiving health and care at the centre of decision making and creates a personalised approach to their care. Its aims of reducing harm and waste, simplifying care while managing risk, and innovating to improve are essential to a well functioning and sustainable NHS," she said.

There is concern, however, that delivering the plans will be difficult. Peter Bennie, chair of BMA Scotland, said: "It is good to see that the CMO recognises the need for innovation within the NHS but, with the ever increasing demand and high levels of long term vacancies, the BMA now regularly hears that doctors do not have the necessary time to do this."

Bryan Christie, Edinburgh

Cite this as: *BMJ* 2017;356:j1058

GENERAL PRACTICES...

have been paid £2.2m collectively to compensate for loss of time in carrying out the administrative work to deal with the backlog of data

Department of Health for England to MPs on the House of Commons Public Accounts Committee during an evidence session for a separate inquiry on 27 February showed that the NHS had identified 173 instances that required further clinical review.

General practices have been paid £2.2m collectively to compensate them for loss of time to deal with the backlog of data.

Richard Vautrey, deputy chair of the BMA's General Practitioners Committee, told *The BMJ*: "This causes me very serious concerns. We have concerns about the way that yet another private company has failed to deliver what they were commissioned to do: in this case, to transfer important clinical information from one bit of the NHS to another, potentially putting patients at risk by failing to do so.

"It could have had an impact on safety for patients. These are hundreds of thousands of clinical documents that a clinician felt was important to pass from one clinician to another."

Shortly after the news emerged, England's health secretary, Jeremy Hunt, was summoned to the House of Commons to answer urgent questions.

Hunt said, "We are assured that the data was not lost. It was kept in a secure setting, which means that it was safe and not breached, nor accessed by anyone else. What didn't happen, and which is what should have happened, was that it was not passed on to the right GP surgery."

Adrian O'Dowd, London

Cite this as: *BMJ* 2017;356:j1059

Realistic medicine is "essential to a well functioning and sustainable NHS"—Catherine Calderwood

DOUGLAS ROBERTSON PHOTOGRAPHY

MEASURES IN THE REPORT, "REALISING REALISTIC MEDICINE," INCLUDE:

- Creating a team within the Scottish government dedicated to implementing realistic medicine across the NHS
- Testing the ideas with the public through surveys and other means, including a citizens' jury
- Producing a national health literacy plan to help patients express their wishes
- Reviewing the current patient consent process
- Publishing a Scottish atlas to improve understanding of unwarranted variations in care
- Making realistic medicine a core component in medical education

FIVE MINUTES WITH . . .

Eric Meyer

Oxford University's professor of social informatics talks about the potential for automation in the NHS

"Lots of stories in the media warn about the risks that automation poses to jobs, but automation offers an NHS under growing pressures from an ageing patient population opportunities to improve patient safety and experience and the working lives of its staff. By identifying the repetitive tasks that doctors and other healthcare staff perform and automating some of those tasks we could free up their time for more important work, more direct patient care, which is also more rewarding for staff.

IDENTIFYING REPETITIVE TASKS AND AUTOMATING THEM WILL FREE UP DOCTORS' TIME

"Our project is attempting to identify tasks that could be automated in general practice, and the potential benefits for the NHS. The tasks that are immediately ripe for automation include dealing with documents, information heavy areas such as flagging potential drug interactions, and communications to patients, including reminders about appointments and repeat prescriptions.

"One of the most important areas where automation could provide benefit would be to enable doctors to access health data that patients collect themselves using devices such as mobile phones and dedicated devices such as Fitbits. Right now there is no way for patients to actually share those data with their doctor. That is a huge gap because it would make the time spent in the consultation more efficient and effective. For example, where a patient had been asked to make dietary changes, the doctor would be able to see how well the patient had been keeping to their dietary regime and deal with any problem areas. At the moment doctors have to spend a lot of time trying to get the patient to remember what they have or haven't done, and patients may be inclined to report that they adhered better than they actually have, because they are embarrassed. There is huge potential in this area for making people's experiences better.

"Getting these data to a doctor is relatively simple technically; the problems are social and organisational, around data sharing and privacy."

Ingrid Torjesen, *The BMJ*

Cite this as: *BMJ* 2017;356:j1040

Four in 10 European doctors may leave UK, BMA survey finds

Poll of non-UK doctors shows potential impact of Brexit on workforce. **Ingrid Torjesen** reports

More than four in 10 doctors from other European Economic Area countries who work in the UK are considering leaving since the referendum result on the UK's membership of the EU, a survey has found.

The BMA's survey of 1193 EEA doctors working in the UK found that 42% were considering leaving since the public's decision that the UK should quit the EU, and a further 23% were unsure whether to stay.

The doctors said that they felt significantly less committed to working in the UK after the referendum result: on a scale of one to 10, their commitment has fallen from an average of nine before the referendum to six after.

They also now felt substantially less appreciated by the UK government: on a scale of one to 10 the average rating dropped from seven before the referendum to four afterwards. However, the doctors said that they still felt highly appreciated by patients.

Around 10 000 doctors who work in the NHS—6.6% of the UK medical workforce—qualified in other EEA countries, and many more EEA qualified doctors work in public health and academic medicine.

The NHS relies on recruiting foreign trained doctors to unfilled vacancies to maintain services, and figures show that the number of unfilled doctor vacancies in England, Wales, and Northern Ireland increased by around 60% from 2013 to 2015, the BMA said. Since the vote to leave the EU the BMA has been urging the government to commit to a future immigration system flexible enough to enable EU and overseas doctors to continue to be employed and recruited, to ensure long term stability in UK health services.

Feeling unwelcome

Mark Porter, BMA council chair, said that many overseas and EU doctors working in the UK "are left feeling unwelcome and uncertain about whether they and their families will have the right to live and work in the UK after Brexit."

"These are the people who staff our hospitals and GP surgeries, look after vulnerable patients in the community, and conduct vital medical research to help save lives," he said. "Many have dedicated years of service to healthcare in the UK, so it's extremely concerning that so many are considering leaving."

Porter added, "At a time when the NHS is already at breaking point and facing crippling staff shortages, this would be a disaster and threaten the delivery

FIVE WAYS TO SUPPORT SAS DOCTORS

The BMA, Health Education England, NHS Employers, and others have produced guidance on the career development of specialty and associate specialist (SAS) doctors in England

1 Consult

Hospital boards should regularly consult SAS doctors to understand the work these doctors do and to consider any support they may need. Boards should find out the proportion of SAS doctors with a mutually agreed job plan or who use their agreed study leave.

2 Encourage

SAS doctors should be actively encouraged to apply for management roles and appropriate consultant posts. Boards should ensure that negative terms such as "middle grade" are not used.

3 Appraise

The guidance says that medical directors must ensure that SAS doctors undergo appraisals each year. Appraisal can help provide evidence of SAS doctors' current level of practice. Medical directors should recognise that SAS doctors can work autonomously.

4 Develop

SAS doctors should be supported by their medical director to apply for a certificate of eligibility for specialist registration where there is a service need that can be met only through increasing the consultant workforce.

6.6% of the UK medical workforce qualified in the other EEA countries

of high quality patient care. But this isn't just about numbers. The quality of patient care is improved where doctors have diverse experiences and expertise.

"The government must act now to ensure long term stability across the healthcare system by providing certainty to medical professionals from the EU about their future in the UK. It must also ensure that a future immigration system allows the NHS to continue employing EU and overseas doctors to fill staff shortages in the health service."

Jane Dacre, president of the Royal College of Physicians, said, "The government, the NHS, and the public need to value and support all NHS staff, wherever they are from. Currently a quarter of NHS doctors are from overseas, and the NHS has benefited from their talents, abilities, and commitment to working with us in the UK. We must continue to support them, despite the insecurity caused by the Brexit situation."

She added, "Medicine is an international profession, with global cooperation in research, drug development, standards of patient care, and free movement of doctors around the world. This model has served the UK and the NHS well for decades: moving away from that model is a major risk to the success of the NHS."

Ingrid Torjesen, London

Cite this as: *BMJ* 2017;356:j988

5 Empower

SAS doctors should themselves be assertive in taking advantage of opportunities available to them and challenge colleagues when these are not open to them.

NHS recruitment from rest of EU is falling because of Brexit, MPs are told

Workforce experts have warned of signs that healthcare staff from other EU countries who were considering coming to work in the NHS are choosing not to do so because of uncertainty over Brexit.

EU staff seem less keen to come to work in the UK, employers are not launching their usual recruitment drives in the EU, and existing EU staff in the NHS are considering leaving, MPs on the parliamentary health committee were told.

At an evidence session for the committee's inquiry into Brexit held on 21 February, MPs asked about the impact on recruitment and retention of health and care staff since the referendum last June.

Giving evidence, Daniel Mortimer, chief executive of NHS Employers, which represents employers in the health service, said, "We are seeing a decrease in recruitment. There are lots of factors going on there. Some of it is because employers haven't been out to recruit because of the lack of certainty, and some of it is because we are not seeing the volume of applications that we've previously seen. And some of it is because perhaps colleagues in those [EU] countries are making some slightly different choices.

"Some hospitals have done a lot of work with their EU nationals, and a number are reporting that the lack of certainty is making them question whether they stay in the longer term. On retention within the NHS, we have put a huge amount of effort into seeking to reassure our EU colleagues and to stress the value that we place on the contribution that they are making."

Daniel Mortimer

David Lomas

EU staff seem less keen to come to work in the UK, and existing EU staff are considering leaving, MPs were told

David Lomas, vice provost (health) at University College London and head of the college's school of life and medical sciences, giving evidence, added his concerns about the negative effect of Brexit on staff.

"I represent the Association of UK University Hospitals," he said. "We have a tripartite mission of clinical care, research, and teaching, so we are the specialist, hard core research and development that drives innovation within the NHS. "We are after the very highest quality of people from around the world that we need to attract to drive our research and development. We have seen concerns among our staff."

Lomas said that he had surveyed a range of hospitals including teaching hospitals before coming to give evidence to the committee and said, "Many of the medical schools across the region of university hospitals—Glasgow and Leeds being two in particular—reported [EU] people pulling out after having been offered jobs, so we've lost stellar people who would have come otherwise."

Effect on grants

Teams applying to the EU for grants for research were also experiencing less success if they had British team members, Lomas added.

"Previously, having a British member and British expertise would help you in terms of your grant application and getting funding, but now you are less of an asset," he told MPs. "The big issue for most of the university hospital academics is applying for grant applications, and we've seen [UK] people bumped off grant applications to the EU."

Later in the session other witnesses warned that the costs of travel health insurance could become too expensive for older people after Brexit if the UK came out of the European Health Insurance Card system, under which UK citizens have a right to free or subsidised medical treatment when they visit other EU countries.

Adrian O'Dowd, London

Cite this as: *BMJ* 2017;356:j966

THE BIG PICTURE

WHO calls for more funds as Yemen's health service collapses

The World Health Organization has made an urgent plea for funding to help its response to the crisis in Yemen.

Nevio Zagaria, WHO's acting representative in Yemen, said that last year WHO received less than half of the $124m (£98m) it needed to support the country, which has been mired in a worsening conflict since 2015.

"We are asked to fill gaps created by collapsing health institutions," said Zagaria. UN agencies and non-governmental organisations working to support healthcare in the country are appealing for $322m, of which WHO is requesting $126m.

"We urgently need resources and are calling on donors to scale up their support before more innocent lives are lost unnecessarily," he added.

Khaled Suhail, director of Al-Thawra Modern General Hospital in Al-Hudaydah, Yemen's third largest city, told WHO that hospital staff had not received their salaries for the past five months. "There are acute shortages of certain medicines, and we need more fuel to ensure the hospital has electricity," he said.

Every day around 1500 people seek care at the hospital. The number has risen fivefold since 2012 because of the influx of people displaced by the conflict and the closure of other health facilities in the area.

Recently the hospital had to stop providing food for inpatients because of a lack of funds, and it has become reliant on WHO donations of fuel and drugs. "With no funds for operational costs, we don't know how much longer we will be open for," Suhail said.

Health facilities across Yemen have reported more than 7600 deaths and nearly 42 000 people injured since March 2015, when the conflict escalated.

The budget allocated to health authorities has been drastically reduced, leaving facilities without funds for operational costs and workers without regular salaries since September 2016, says WHO. It estimates that 14.8 million people in the country lack access to basic healthcare.

Specialised medical staff, including intensive care unit doctors, psychiatrists, and foreign nurses, have left the country.

Anne Gulland, London

Cite this as: *BMJ* 2017;356:j1035

A Yemeni girl receives treatment for malnutrition at a hospital in Sana'a last month. Unicef has reported that at least 462 000 Yemeni children have severe acute malnutrition, as food supplies have been disrupted by the nearly two year long conflict between Yemen's Saudi backed government forces and Houthi militias

YAHYA ARHAB/EPA/REX/SHUTTERSTOCK

EDITORIAL

Measuring what matters to patients

OECD health ministers commit to patient reported measures of performance

Jeremy Hunt and fellow health ministers at the OECD meeting in Paris on 16 January 2017

We need to invest in measures that will help us assess whether our health systems deliver what matters most to people.[1] So said the health ministers from various Organisation for Economic Co-operation and Development (OECD) countries at a recent meeting in Paris. Reliance on mortality rates and clinical indicators gives only a partial view of the value of health care, they concluded. What people really care about is its impact on their wellbeing and their ability to play an active role in society, so that's what we should be measuring. And, of course, the only way to do this is to ask patients themselves.

What people really care about is its impact on their wellbeing and their ability to play an active role in society

Groundbreaking statement

This groundbreaking ministerial statement endorsed plans for a major programme of work on patient reported indicators of health system performance.[2] Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) seem set to become the new currency for comparative performance assessment, but they may have an even more important role in clinical care.

Patient experience surveys elicit feedback on the process of care rather than its effects, focusing on issues such as communication with health professionals, information provision, involvement in decisions, physical comfort, emotional support, and care transitions. Achieving benefit from this resource requires well designed questionnaires and a commitment to act on the results. This is sadly not always the case,[3] so the OECD's championing of such surveys is most welcome. The OECD secretariat has persuaded authorities in 19 countries to adopt a common set of PREM indicators to enable comparison of the quality of ambulatory care, and they plan to extend this approach to encompass other settings, services, and conditions.[4]

PROMs are standardised questionnaires to elicit people's subjective reports of the personal impact of illness and treatment—in other words, health related quality of life. The results can be compared with previous measurements from the same individual or group (to measure change over time) or with those from a reference group or subgroups (to compare against an external norm or standard).

Putting theory into practice

The OECD report details challenges that must be overcome if PREMs and PROMs are to be used to compare health system performance across countries. These include achieving consensus on what to measure and how to measure it; selecting appropriate instruments; identifying suitable sampling frames; controlling the quality of data collection; avoiding response bias; and minimising survey fatigue.

A particular challenge is to measure outcomes of care for people with long term conditions, especially those living with multimorbidities. In this case, professional interventions should be focused on helping people to self manage, prevent exacerbations, and achieve their personal goals, so indicators focused on physical functioning may not be particularly relevant. We need to use PROMs that encompass a broader view of health and wellbeing.

Multipurpose applications of PREMs and PROMs—using them in individual clinical care and aggregating the data for performance assessment—remains largely aspirational at present,[7] but in mental health the Improving Access to Psychological Therapies (IAPT) programme is making strides in this direction. This programme for treating people with anxiety and depression has shown how PROMs can be used both as a clinical tool to inform the management of individual patients, and as key performance indicators across a programme that treats nearly a million patients in England each year.[8]

Encouraging clinicians and patients to make greater use of these tools in regular care may prove fruitful. Their use in virtual clinics—where patients complete PROMs online to enable remote monitoring, thus avoiding unnecessary hospital appointments—is another potentially exciting application.[10]

The use of patient reported indicators has great potential, but many clinicians still need to be convinced of their validity and utility.[11] They will want reassurance that the process can be fitted into care pathways without causing disruption, and that any conclusions based on aggregations of the data are valid. Patients will want to be assured that the time they spend completing PREMs and PROMs questionnaires will be rewarded by better care.

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EDITORIAL

Challenges of managing chronic pain

Start by ensuring realistic expectations

Chronic pain is an individualised experience with multifactorial aetiology.[1] It can cause unexpectedly prolonged suffering when, for example, an initial injury evolves into a complex disease state. A transient ankle sprain may turn into a complex regional pain syndrome lasting for months to years; or a week long episode of shingles may cause post-herpetic neuralgia with disabling pain for months or years. Moreover, chronic pain can be an accompanying symptom of largely irreversible underlying disease, such as degenerative arthritis (osteoarthritis), spinal stenosis, or compression fracture resulting from osteoporosis in older people. Chronic pain can also be a primary complaint of clinical conditions such as fibromyalgia and trigeminal neuralgia, for which neither the aetiology nor mechanism is currently well understood.

Different approaches required

Chronic pain is therefore not simply a chronological extension of acute pain. It requires different diagnostic approaches and management strategies. For example, diagnostic tools such as radiography and magnetic resonance imaging are less informative in identifying the source because the severity of chronic pain can be disproportionate to the underlying cause[2]; chronic pain is typically associated with and exaggerated by coexisting conditions such as anxiety, depression, catastrophising, and disability; and the effectiveness of medications used for acute pain can diminish over time because of tolerance (for example, with opioids) or increased side effects.[3]

Managing chronic pain is to fight a "war," not a "battle." Both clinicians and patients must start with the right expectations and develop a long term strategy with full awareness of the complexity of the problem. Patients with diabetes do not expect control after a single course of treatment—they expect a long term plan that includes diet, exercise, medication, education, and prevention. Patients with chronic pain (and their doctors) should expect a similar long term multifaceted approach. Unrealistic expectations of a "quick fix" can become an iatrogenic source of anxiety for patients and result in unnecessary medicating and dose escalation (including overprescribing opioids) or overzealous interventions (such as unnecessary surgery or nerve blocks) by clinicians looking for short term gains.

All commonly used analgesics have important limitations when used for chronic pain. For example, prolonged use of paracetamol (acetaminophen) can cause changes in liver function that are exacerbated by concurrent alcohol consumption,[4] and non-steroidal anti-inflammatories are associated with potentially serious renal, gastrointestinal, and cardiovascular side effects.[5] Opioid analgesics have been increasingly used in many countries over several decades, particularly in the US.[6] But aside from well known side effects such as constipation and sedation (particularly in older people), long term treatment with opioids can also lead to tolerance, hyperalgesia, addiction, and misuse.

Opioids can and should be used when indicated, but a plan without opioids should not be viewed as incomplete or inferior

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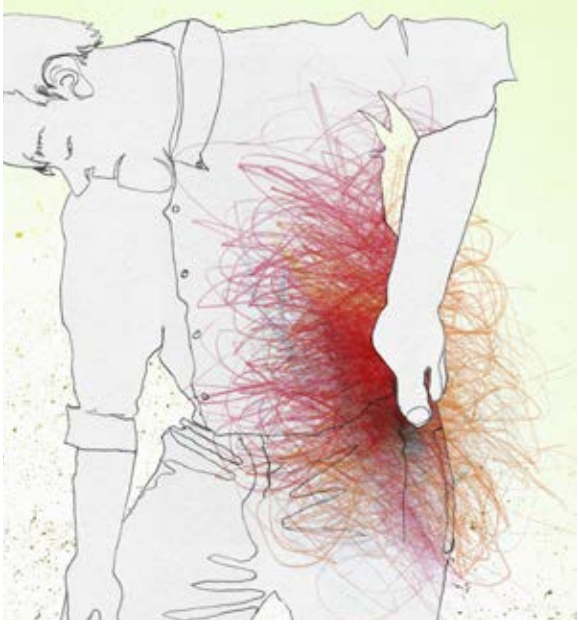

These serious issues are at the heart of an ongoing and well publicised "opioid crisis" in the US that includes worsening overprescribing and rising rates of overdose related deaths.[6 7] An opioid prescription should not be a litmus test of the adequacy of individual pain management plans. Opioids can and should be used when indicated, but a plan without opioids should not be viewed as incomplete or inferior.

Long term strategy

Primary care clinicians, surgeons, and emergency department doctors are in the frontline of pain management, and they have a pivotal role in initiating and developing a long term strategy that includes prompt referral to pain specialists. Other key components of a comprehensive management plan include treating underlying conditions; using multiple drugs, including muscle relaxants, antidepressants, anticonvulsants, and topical agents as well as conventional analgesics, to optimise the effectiveness and minimise side effects[8]; adding psychological interventions and physical therapy; and considering integrative approaches such as acupuncture and mind-body therapy.[9 10]

It helps to remember that pain is a defence signal and its proper function is necessary for our survival. The aim of chronic pain management is not to get rid of the defence signal but to adjust its threshold so that the signal will not go off inappropriately. This goal is perhaps the ultimate challenge in managing chronic pain and has been the subject of decades of effort in pain research.[2]

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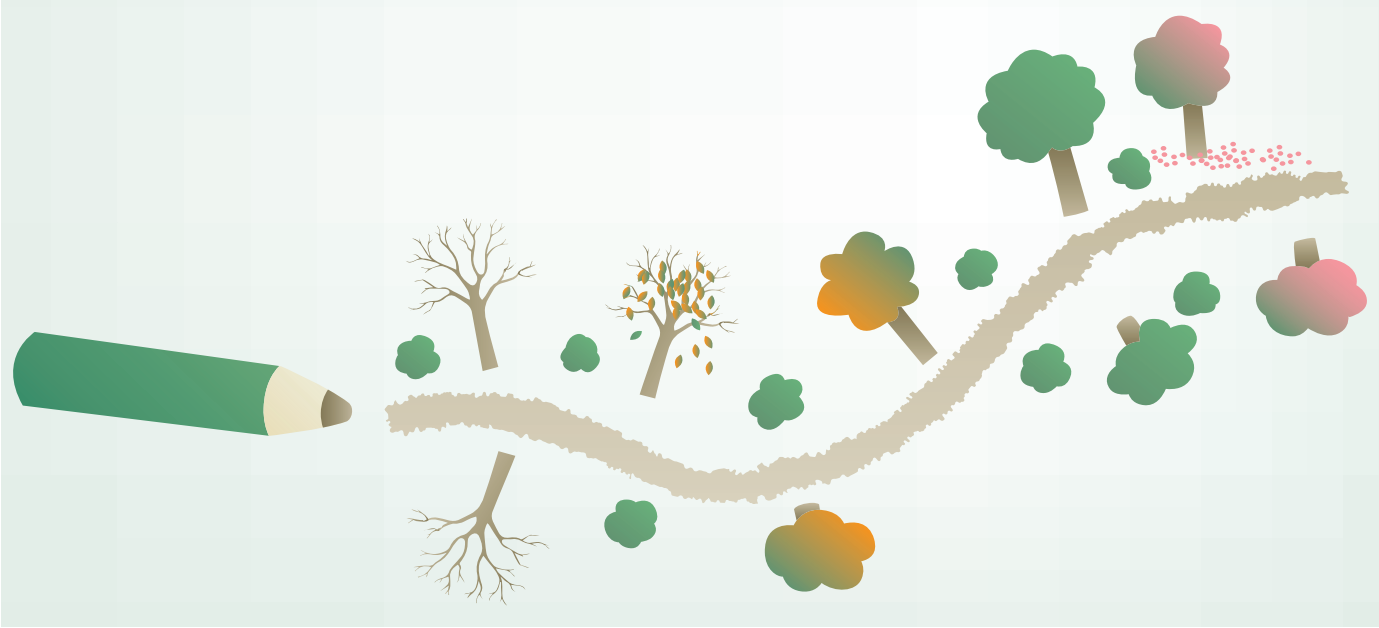
For a patient perspective go to http://bmj.co/patient_chronic_pain



ANALYSIS

Palliative care from diagnosis to death

Evidence is growing that people can benefit from palliative care earlier in their illness, say **Scott Murray and colleagues**, but care must be tailored to different conditions

Many people still associate palliative care with care in the terminal stage of cancer, and patients with cancer remain more likely to receive it than those with other illnesses.[1] It is often delayed until the last weeks or days of life once the illness is advanced and disease focused treatments are no longer effective. However, late palliative care is a missed opportunity to do better for patients, families, and health services. In high income countries, up to 80% of people who die could benefit from palliative care much earlier in their illness.[2]

Late palliative care is a missed opportunity to do better for patients, families, and health services

KEY MESSAGES

- Palliative care should start at diagnosis and not be confined to the very end of life
- Early palliative care improves quality of life by focusing on living well with deteriorating health
- All health professionals need to incorporate holistic palliative care into their practice
- An understanding of typical, multidimensional illness trajectories can help doctors know what to offer and when

The World Health Organization adopted a resolution on early palliative care in 2014. It states that palliative care should be considered from diagnosis onwards and integrated into care for people with any condition that means they may die in the foreseeable future.[3] Palliative care can improve the quality of life of patients and their families through timely identification of deteriorating health, holistic assessment of needs, management of pain and other problems (physical, psychosocial, and spiritual), and person centred planning of care.

By embracing the principles of palliative care in their routine practice, clinicians can meet the multidimensional needs of people with deteriorating health more effectively.

Evidence for early palliative care

Randomised controlled trials and other studies show multiple benefits from early palliative care. A landmark randomised trial comparing standard care with outpatient specialist palliative care integrated with oncology for patients with advanced or metastatic disease improved quality of life and, for some people, longevity.[5] It can also help avoid burdensome interventions of low benefit.[9] Studies of older people in Australia and people with chronic disease in Canada showed significant reductions in hospital admissions.[10-12]

Patients have been shown to have palliative care needs from diagnosis.[13] Although trials do not explain which aspects of palliative care are the most important, helping people to make choices aligned with their priorities seems to be the key.[14]

Below we set out a rationale for early palliative care based on the three typical trajectories of functional decline towards the end of life (rapid, intermittent, and gradual)[15 16] and suggest how it can be incorporated into disease specific care.

Rapid functional decline

In people with advanced cancer, social functioning typically declines in parallel with physical decline, whereas psychological and spiritual

wellbeing often fall together at four key times: around diagnosis, at discharge after initial treatment, as the illness progresses, and in the terminal phase (fig 1). Patients and family members report that the time around diagnosis is one of the most traumatic, psychologically and existentially, with further emotional turmoil as the patient gets more ill.[17]

All people whose cancer may be life limiting, but not necessarily untreatable, should be considered for palliative care from diagnosis. They can benefit from holistic care and support as well as planning care even when they may be relatively well physically. Patients report finding it supportive for professionals to simply acknowledge that this initial time can be very challenging. Some also value being told about the likely course of events for people with their condition. Triggers for a review of palliative care needs include discharge from hospital after treatment, poorly controlled symptoms, falling performance, and other clinical evidence of disease progression.

Intermittent decline

In people with life limiting, long term conditions or multiple illnesses, the dynamic "four dimensional" pattern of needs is different from that for most progressive cancers. Social and psychological decline both tend to track the physical decline, while spiritual distress fluctuates more and is modulated by other influences, including the person's capacity to remain resilient (fig 2).[16] People may die suddenly during an exacerbation or when still functioning relatively well, so death is often perceived as unexpected, although it has actually been a predictable risk for some years.[18]

Early palliative care is about doing more for the person, not less

During the increasingly frequent exacerbations of conditions such as heart failure, liver failure, or chronic obstructive pulmonary disease, patients and their carers are anxious, need information, and often have social problems. Support for these needs might be more effective and likely to reduce hospital admissions than interventions focusing on disease management or physical wellbeing. Planning for exacerbations should include dealing with multidimensional needs and communicating current plans and patient wishes regularly and routinely to out-of-hours care providers and hospitals. This facilitates appropriate management during and after such crises.[19]

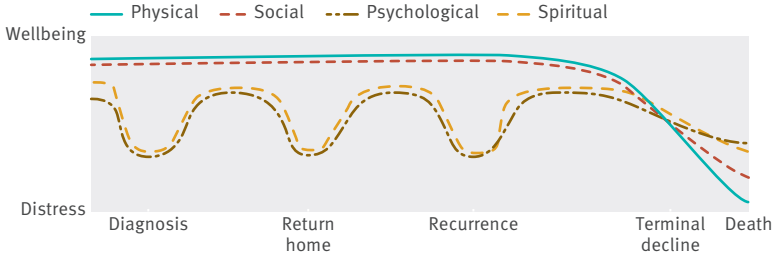


Fig 1 | Wellbeing trajectories in patients with conditions such as cancer causing rapid functional decline

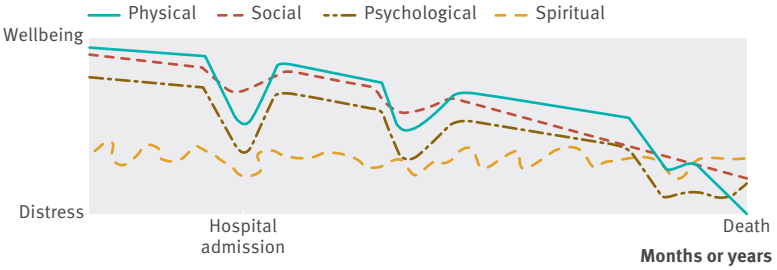


Fig 2 | Wellbeing trajectories in patients with intermittent decline (typically organ failure or multimorbidity)

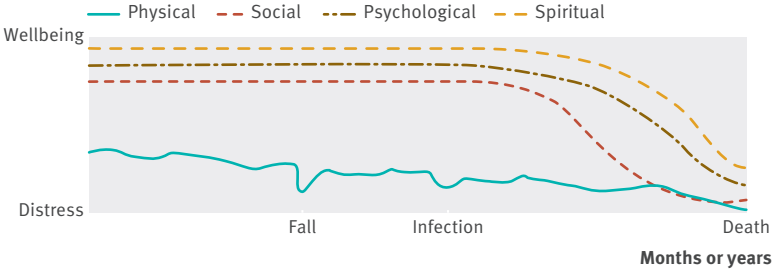


Fig 3 | Wellbeing trajectories in patients with gradual decline (typically frailty or cognitive decline)

INTRODUCING EARLY PALLIATIVE CARE

- Talk about why starting a conversation about what is happening is important:
  - "When someone has this sort of health problem, we usually plan to have a talk together about what is happening and what help they might like to have now or in the future…"
  - "The treatment has helped this time and I am glad you feel better, but I am worried you may get unwell again so can we talk about how we might plan for that…?"
- Ask who should be involved:
  - "What would be the best way for us to talk about this? People often like us to involve a family member or close friend…"
- Talk about the main aims of the conversation:
  - "We want to find out about the things that are important for you like what you'd like to be able to do now and in the future…"
  - "We can talk about your current situation and what you want to know about your health problems…How have you been doing recently?"
  - "This is a good time for us to talk about any thoughts or worries you might have about the future…"
- Ask what the person knows, has been told, and thinks could happen to them
- Talk about what might happen linked to this understanding and awareness using short "chunks" with pauses and time for questions or reactions
- Ask what matters most so that good plans can be made
- Talk about getting advice from a colleague who can help you look after them well if the situation is more complicated or unstable. Explain that palliative care is all about what we can do to help people stay as well as possible

Gradual decline

People who have frailty, dementia, or a progressive neurological disease, including those with long term disability after a severe stroke, typically experience a gradual physical decline from a limited baseline and a diminishing social world. [20] Psychological and existential wellbeing sometimes fall in response to changes in social circumstances or an acute physical illness but a decrease in social, psychological, or existential wellbeing can herald global physical decline or death (fig 3). Some older people reach a tipping point when they feel unable to live usefully or with dignity and experience increasing psychological and existential distress before dying.[21]

Actions to promote optimum physical health should be combined with help to engage with social support and care that let frail older people maintain a sense of self and purpose even in the face of increasing dependence. Allowing older people to raise and discuss their greatest fears—of losing independence, dementia, or being a burden to others—is person centred early palliative care. Anticipating and planning for deteriorating health in older age can reduce distress while promoting a realistic understanding of normal ageing and how death occurs at the end of a long life. People with early dementia or progressive neurological conditions need holistic palliative care and support to plan ahead from the time of diagnosis.

Early care for all conditions

Lack of timely identification of people who may benefit is the greatest barrier to early palliative care. In the same way that we screen for cardiovascular risk factors or for diabetes, we should routinely and systematically consider whether our patients might benefit from early palliative care. Signs of decline in general health or specific conditions can be combined with triggers such as unplanned admissions, poorly controlled symptoms, or increasing need for carer support. Screening can happen at treatment reviews, at hospital admission or discharge, or at annual medical examinations in older people. Action before the last weeks or days of life means accepting prognostic uncertainty instead of relying on mortality prediction tools that do not work for individuals.[1 24]

Good conversations

Early conversations suggesting that it is helpful to start talking about what might happen in the future and available treatment and care options should be introduced sensitively.[14] Explaining the inherent uncertainties of life limiting illness is different from breaking bad news. It requires an ongoing discussion about what might happen and what could help.[25] There are many well validated guides to help clinicians to explore people's understanding, share individualised information, respond to emotions, and acknowledge loss so that care is tailored to each person's needs and priorities. The content and the context of such conversations should be relevant to the person's current state and involve those close to them.[14-28]

Many clinicians find it challenging to raise palliative care with patients because it is associated with imminent death. In Canada and the UK some palliative medicine physicians use the term "supportive care" to promote access.[29] In one study many patients who experienced early palliative care thought it should be renamed.[30] Practical aspects of doing this have recently been reviewed.[31] A natural experiment of using the term "anticipatory care" throughout Scotland found that it enabled earlier conversations. Planning for possible deterioration made it much easier to discuss and plan for likely events in the illness trajectory, including dying. More patients subsequently received this planned holistic care before dying.[19]

Integration with ongoing disease management

Integration is the only way that early palliative care can be widely available and acceptable to most people. Open dialogue and planning should occur in the community, care homes, and hospital wards, so that everyone who needs it can benefit.[32] Communication between settings is vital. Hospital specialists, specialists in palliative care, general practitioners, community nurses, patients and carers, and providers and commissioners of care must all be included.

Early palliative care requires doctors to be alert to the opportunity to introduce it, to listen to what the person thinks is important

Several such initiatives have already been implemented in health systems throughout Europe.[33] A WHO web platform dedicated to integrated people centred palliative care (www.integratedcare4people.org/communities/integrated-people-centred-palliative-care/) has been launched to share good practice, experiences, and lessons.

Early palliative care requires doctors to be alert to the opportunity to introduce it, to listen to what the person thinks is important, and to offer ongoing support. Understanding typical patterns of decline and distress enables professionals, patients, and their carers to share a realistic view and include palliative care to prevent as well as treat distress. Explanation about when practical, emotional, and existential issues might occur, and the help available, helps empower patients and provides real hope. Early palliative care is therefore about doing more for the person, not less. Indeed it might be best not to call it palliative care, but just good patient centred care and planning, to which we should all aspire.

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In the past two years, three of the UK's leading hospital trusts have appointed candidates from overseas to be their chief executives. **Tom Moberly** looks at what these international recruits are bringing to the NHS

TIM BRADFORD

COVER STORY

The world class talent signing for team NHS

What links the leading acute trusts, University College London Hospitals, Great Ormond Street Hospital, and Oxford University Hospitals? Answer: they have all appointed their chief executives from overseas. Marcel Levi, from the Netherlands, is newly installed at UCLH; Peter Steer, from Australia, has joined Great Ormond Street; and Bruno Holthof, from Belgium, runs the Oxford trust.

That UK hospital trusts are buying in management talent from abroad isn't new. Keith McNeil came from Australia to run Addenbrooke's Hospital in 2012, Tracey Batten, also from Australia, joined Imperial College Healthcare in 2014, and Robert Bell, longtime chief at the Royal Brompton and Harefield NHS Trust, hails from Canada.

"It is undoubtedly useful to have people who bring new perspectives and who may be less hidebound by the NHS way of thinking"

But Nigel Edwards, chief executive of the Nuffield Trust think tank, identifies a recent rise in the number of international chief executives recruited to NHS trusts. "The calibre of the people they are appointing is very impressive," he says. "And it is undoubtedly useful to have people who bring new perspectives and who may be less hidebound by the NHS way of thinking." Edwards says the fact the NHS has found it necessary to recruit from abroad points to a lack of suitable UK candidates. "There is an increasing difficulty among large trusts in finding people willing to take on these big roles, which might explain why some organisations have gone for international recruitment." However, he adds: "This is relatively new, but there is not enough of this to call it a trend."

Tough space

Steer says that part of the problem in attracting UK talent to chief executive roles is the demands inherent in these roles.

"We've seen huge turnover and we still have a pretty short half-life of CEOs across the NHS," he says. "They aren't attractive roles when the political and media scrutiny can sadly be framed as a blame culture, rather than an instructive one where we're all actually on the same side."

The lack of a career structure to enable chief executives to work up from smaller to larger NHS organisations also causes problems, he says. "The minute you start as a CEO, no matter where you are, it's a tough space."

Edwards points out that, so far, the trusts that have recruited chiefs from overseas are mainly larger and more complex NHS organisations. "They tend to already have a more international mindset due to their extensive academic activity," he says.

In London, Levi believes one of the reasons that chief executives in larger trusts have been recruited from overseas is that the roles are sufficiently challenging to attract overseas candidates. "It is an attractive job," Levi says. "And mostly they come from a good job and they want to develop," he says.

Levi is one of several chief executives to head abroad from the Netherlands—to Sweden, for example—leading to comparisons in the Dutch media to Premier League football players. "They said it's usually only soccer players and business leaders that go to another country, but now we are like an export industry," Levi says.

Steer feels he has reached a career pinnacle in joining Great Ormond Street, and that there may be nowhere else for him to go. He describes his current roles as the "best job ever." "I don't know what I'd do after this," he says. "I really don't. It's actually quite a problem."

Tom Moberly, UK editor, *The BMJ*

Cite this as: ***BMJ*** **2017;356:j1036**

BRUNO HOLTHOF

Bruno Holthof joined Oxford University Hospitals in October 2015. He was previously chief executive of Antwerp Hospital Network, in Belgium, and before that worked as a partner at the consultancy firm McKinsey.

"One of the areas where I think the NHS can learn from other health systems is in developing frontline leadership and being capable of executing change. It's not a lack of ideas on service innovation; it's how you get to implement them. The NHS is very well aware of the innovations happening in other healthcare systems whether that's in the US, Europe, or Asia.

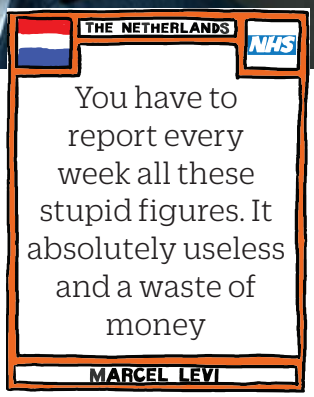
"My strong belief is that implementing innovation involves a lot of hard work, and the work happens at the front line. If you want to change how patients are being cared for in a hospital ward, you need a lead consultant and sister responsible for the work to be driving that work. Change doesn't happen nationally or at the board level of institutions. It happens in those frontline positions.

"The other thing I think the NHS can learn is how you do those change programmes. My experience is that successful programmes in other systems take a long time. They take at least five years to have an impact. You need to involve a lot of lead consultants and sisters in the change, and not just in a single institution, but also in general practices, community services, and social care.

"We're not changing our healthcare system by developing presentations or filling in templates. In McKinsey I was very much involved in innovation and how innovation can increase productivity. I think productivity is the solution for the NHS. We need to be able to become the most productive system in the world, given the budget limitations of the NHS.

"For me, the solution to increasing productivity is innovation and bringing innovation from either academia or other leading healthcare companies into the NHS. But it's a very tough job. Bringing innovation into the NHS and increasing productivity requires frontline clinical engagement and an ability to embrace innovation. I have to explain to the clinicians who are leading these services how to do it and how difficult it is.

"If you want to increase productivity of the system, it requires significant change. You can't do that without closing capacity, reallocating capacity, redeploying the workforce, and retraining the workforce. So it has significant implications for people and infrastructure."



MARCEL LEVI

Marcel Levi has been chief executive of University College London Hospitals since January. Previously, he was chair of the University of Amsterdam's department of medicine and division of medical specialisms.

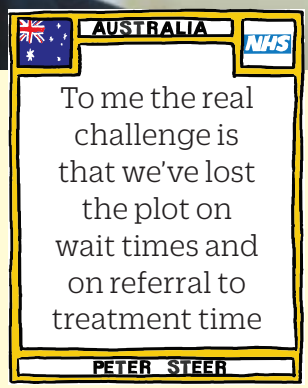
"I did a similar job in the Netherlands, so there are not many surprises in terms of the work and the people. I thought the system would be very different from the system that I was used to in the Netherlands. But I've been here for six weeks now and I think the biggest discovery is that there are actually more similarities than differences between the two systems.

"One of the big things in my previous job was fighting against bureaucracy. The amount of control and bureaucracy here is absolutely stunning. I've never experienced something like this in my entire life. Even if your trust is running okay—financially, in terms of quality and everything—you have to report every week all these stupid figures. I have at least 50 people here working on that. It's incredible the amount of money and energy that we have to spend on it. It's absolutely useless and it's a waste of money.

"I think we can improve a lot of things for junior doctors. I come from a system where the junior doctors are extremely important in the hospital. I hate the idea that they are only here for one year. In the Netherlands, we mostly have three years in one hospital and then three years in another hospital. We're trying to think about ideas about how to keep them here a little bit longer and we may be in a position to do that—for example, to combine research positions and training positions for some of them.

"One of the urgent things—and that's what my next meeting is all about—is the lack of proper digitisation of the UK healthcare system. I go around the hospital, and it's like going back in time 15 years. It's incredible. There are kinds of problems that I'd almost forgotten; we just had an electronic system, so everything was there.

"If we had a good electronic system in place our consultants could access their patient information from everywhere, from their home, from their other clinics, or wherever they are. It's such a big improvement, and we have to have it—we are so far behind."



PETER STEER

Peter Steer has been chief executive of Great Ormond Street Hospital since January 2015. He was previously chief executive of Children's Health Queensland Hospital and Health Service, and he has also worked in New Zealand and Canada.

"It's interesting how often things seem very much the same despite some very significant differences in geography. Having worked in other highly charged political environments has been valuable in that it has meant that I haven't been surprised here.

"I've also been fortunate to have had some experience with capital development and funding. We are in this fairly tight and brownfield inner city site in the middle of London. It's both expensive and challenging to rebuild. So having had some of that experience before has been valuable—parachuting into that particular challenge anew and fresh, without experience, would have been quite challenging.

"One of the things that is quite challenging in the NHS is the extraordinary fragmented nature of the system. Since the last reforms it is an incredibly complex, layered, and burdensome system from the commissioning and funder end.

"One of the results of that fragmentation is that we do spread our leadership and management talent thinly.

"Given the complexities of commissioning healthcare for a population, to think that any country could stand up over 200 [clinical commissioning] groups of really super competent efficient bodies to do such a thing overnight is a bit of a stretch.

"To me the real challenge is that we've kind of lost the plot on wait times and on referral to treatment time. I think there's a real risk, not only that we are over promising politically and bureaucratically but that there's no way we could deliver on the promise. We're setting ourselves up to fail.

"More importantly, I think we're on a narrative here that is dangerous in terms of our clinician engagement. If we're setting the system up to fail, and if our clinicians are disengaged from this story around timely clinically appropriate access, we're going to have another bigger problem in the future. I think it's a little bit more rational in Australia. There has been some great work done—and I've got a paediatric lens on this—in terms of solutions to paediatric access issues that have been genuinely consensus and clinically based and where you can get genuine buy-in from providers and clinicians."

ILLUSTRATION: DUNCAN SMITH

Ian Gilmore, chairman of the Alcohol Health Alliance and of Liverpool Health Partners, is a gastroenterologist and hepatologist whose professional life provided him with ample evidence of the damage alcohol can do. He was president of the Royal College of Physicians from 2006 to 2010, and under his leadership the college launched the alliance, which favours minimum unit pricing and restrictions on advertising to reduce harms related to alcohol. He was a member of the committee that recommended cutting the advisory limit for men from 21 to 14 units a week, the same as women, earning a raspberry from the saloon bar.

BMJ CONFIDENTIAL

Ian Gilmore
Fighting alcohol's harms

What was your earliest ambition?
I had a childhood immersion in the "three professions" through parents and grandparents. The church ran a distant third, but medicine and the law were neck and neck until A level choices forced a decision. I am still in awe of the ability of barristers to dissect an issue and pursue an argument.

Who has been your biggest inspiration?
Certainly the most influential post was as senior house officer on the intensive therapy unit at St Thomas', where the physician Ron Bradley taught me how to calmly approach the problem of the acutely ill patient, rather than panic.

What was the worst mistake in your career?
Not collecting systematic data on my patients from day one and being too lazy to follow up a few hare brained research ideas—and then seeing others bring them to successful fruition.

What was your best career move?
Moving from London to Liverpool against the advice of my bosses at the time. It has been a great place to be and is an endless source of stories.

Who has been the best and the worst health secretary in your lifetime?
Of all I worked with, Frank Dobson was the most human and Alan Johnson the smartest politician. Let's pass over the most recent two.

Who is the person you would most like to thank and why?
I wish I had expressed more appreciation to my parents when I had the chance.

To whom would you most like to apologise?
To my wife and the scores of junior doctors who tolerated my late Friday evening ward rounds for 20 years.

Where are or were you happiest?
With my wife and family playing golf in Donegal, on the rare occasions I play well.

What single unheralded change has made the most difference in your field?
Professionally, fibreoptic endoscopy. Personally, the laptop.

Do you support doctor assisted suicide?
I understand where it's coming from but remain unhappy with the practicality.

What book should every doctor read?
The autobiography of Gerald Ratner reminds anyone in the public eye that a single ill considered remark can have sudden and catastrophic consequences.

What, if anything, are you doing to reduce your carbon footprint?
An electric car and drinking French rather than New World wines.

What personal ambition do you still have?
To expire suddenly when the moment is right.

Summarise your personality in three words
Sociable, dutiful, lucky.

Where does alcohol fit into your life?
Professionally, 80%; personally, 20%.

What is your pet hate?
TV adverts for gambling, alcohol, and pay day loans.

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