this week

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NICE too lax on patient group COIs

Patients' groups involved in assessing treatments for the NHS often fail to disclose financial interests, a review published in *The BMJ* shows. More than two thirds of patient groups involved in NICE technology appraisals received funding from the manufacturer of the treatment being assessed or from a competitor, the review found, but did not declare that interest.

Researchers, led by Kate Mandeville at the London School of Hygiene and Tropical Medicine, assessed 53 patient organisations that contributed to 41 NICE technology appraisals published in 2015 and 2016. The organisations contributed to an appraisal on 117 occasions. The researchers found that 38 of 53 groups (72%) had received funding from the manufacturer or competitor in the same or preceding year that they contributed to the appraisal. NICE's committees were aware of less than a quarter of these interests (30 of 144). For nearly two thirds of the non-declared interests (71 of 114), disclosure was not a requirement of NICE policy.

The average annual funding received by the patient groups from manufacturers was £39 000.

The researchers called for stronger policies on disclosure and greater transparency. "NICE's disclosure policy does not provide enough information on funding from drug manufacturers," said Mandeville. She said that the policy was "out of line with international best practice and risks diminishing the voice of patients."

The researchers recommended the extension of NICE's disclosure policy to patient groups as well as individuals and that groups should not accept funding from manufacturers for at least a year before and after any advocacy activities.

Gill Leng, deputy chief executive at NICE, which is reviewing its conflicts of interest policy, said, "Ensuring that all invited organisations declare potential conflicts of interests is essential in maintaining public and professional confidence in our work."

She added that although NICE was aware that some patient groups received funding from life sciences companies, it had not been aware of the extent. "They do not represent direct financial interests under our current policy, although we would expect any indirect financial interests to be declared, and we are disappointed if that has not been the case," she said.

RESEARCH, p 102

Harriet Pike, Cambridge

Cite this as: *BMJ* 2019;364:l217

NICE appraisal committees were unaware that some patient group members had financial links with the manufacturers of products under consideration

LATEST ONLINE

- Develop new roles to retain senior GPs, says review
- A&E registrar is struck off for repeated sexual harassment of staff nurse
- Sudanese doctors appeal for support as hospitals and staff are attacked by regime forces

SEVEN DAYS IN

Doubling NHS surcharge "punishes" international doctors for working in UK

The government is maintaining a "hostile environment" for overseas medics by doubling a levy paid by migrants seeking work here, doctors' leaders have warned.

The BMA said that the Home Office's decision to raise the immigration health surcharge from £200 to £400 a year was "absurd" and would "punish" international doctors at a time of major NHS staffing shortages. A BMA spokesperson said, "With Brexit mere weeks away, Britain must present itself as a welcoming place for doctors and other healthcare workers to come and work. However, this move sends the exact opposite message. We would like to see doctors exempt from this charge."

The surcharge is the annual fee people from outside the European Economic Area must pay to use the NHS when they come to work here for more than six months. In response to criticism of the doubling of the surcharge on 8 January, the Home Office said the average annual "cost of NHS usage" by people paying the surcharge is around £470 and that doubling it could generate an extra £220m a year. A spokesperson said, "We believe it is right that long term migrants make a fair and proportionate contribution to the NHS's long term sustainability."

Matthew Limb, London Cite this as: *BMJ* 2019;364:l128

Assisted dying

RCP seeks members' views on possible law change

A poll by the Royal College of Physicians will seek members' views on whether the law should change to permit assisted dying. A 2014 survey found that most respondents did not support a change: 44.4% said that the RCP should oppose assisted dying, 31% said that it should be neutral, and 24.6% said that it should be in favour. The RCP said that it will adopt a neutral position until two thirds of respondents say otherwise. Members will have two weeks to respond to the poll, which will be sent out in early February. Results will be released in March.

Mental health

Workforce crisis must be tackled, says BMA

Efforts to deal with the workforce crisis in mental health services must be ramped up, said Gary Wannan, deputy chair of the BMA Consultants Committee, in response to a damning report from the Public Accounts Committee. The report found that only three in 10 young people with a mental health condition received NHS funded treatment in 2017-18, and many more faced long waits. Wannan highlighted a lack of detail on workforce issues in the government's 10 year NHS plan. "The £2.3bn allocation for mental health as part of the long term plan is not proportionate to the amount needed," he said.

Public health

Invest to halt drug resistant STIs, say directors

An extra £3.2bn a year in public health grants is needed if health systems are to stop the growth of drug resistant sexually transmitted infections, the Association of Directors of Public Health warned. It called for the extra funding after new cases of gonorrhoea (above) with high level resistance to azithromycin and ceftriaxone were confirmed in England. The association said that extra funds were the only way to maintain levels of service and to tackle new threats.

UK needs hunger minister, say MPs

The parents of nearly a fifth of UK children under 15 cannot afford food, and half of these children are severely food insecure, said the Environmental Audit Committee. The Food Foundation told the committee that this makes the UK "one of, if not the, worst performing nations in the EU." The MPs urged the government to appoint a minister for hunger to act on food insecurity.

Inquiry into unhealthy food and drink promotions

The government launched a 12 week consultation on proposed rules to curb retail promotions thought to cause children's excessive consumption of food and drink high in fat, sugar, and salt. It asks for views on curtailing multi-buy promotions such as "buy one, get one free" and those at checkouts and the end of aisles. Parveen Kumar (above), BMA board of science chair, said that such promotions undermine parents' attempts to make healthier choices for their children.

Workforce

GMC to test more overseas doctors

The GMC will open a new test centre for overseas doctors wishing to sit its Professional and Linguistic Assessments Board exams. Doctors from outside the European Economic Area must pass these exams before they can practise in the UK. The number taking the exams rose by over 75% from 2017 to 2018. The new centre, opening later this year in Manchester, will allow 11 000 doctors to be tested a year, twice the current number.

GP premises

Patients fear being overheard in surgeries

Over half (58%) of patients who answered a Patients Association poll were worried about being overheard when speaking to a receptionist or consulting with a GP. They also said that surgeries were hard to access, particularly by disabled people, and that waiting rooms were outdated and too small. Some GP premises may breach data protection, disability, or health and safety legislation, the association warned.

MEDICINE

Research news

Eating fibre may cut heart disease risk

Convincing evidence shows that nutrition guidelines should focus on increasing dietary fibre and on replacing refined grains with whole grains to improve health, said researchers. Results from WHO commissioned studies, reported in the *Lancet*, showed a 15-31% decrease in all cause and cardiovascular mortality and in incidence of coronary heart disease, stroke, type 2 diabetes, and colorectal cancer when comparing people who had the highest dietary fibre intake with the lowest consumers.

Mesh complications raise depression risk

Women who need a surgical intervention for complications after a mid-urethral mesh sling procedure have a notably higher risk of new onset depression and self harm, a Canadian population based study found. "Women can be profoundly affected by complications, and even with surgical revision the symptoms of these complications may not be completely corrected," said the researchers, who published their findings in *JAMA Surgery*.

Abortion

Court allows challenge to clinic censorship zone

The Court of Appeal granted permission to hear a challenge against a council's public spaces protection order (PSPO) that criminalised prayer and support outside a London abortion clinic. Alina Dulgheriu, a mother supported by a pro-life vigil outside the clinic, had filed a High Court challenge to Ealing council's PSPO in April 2018. The High Court accepted her rights to freedom of expression, religion, and assembly had been infringed, but it upheld the PSPO. The Court of Appeal will now consider whether Ealing's PSPO is lawful.

NHS

Productivity outstrips rest of economy

NHS productivity in 2016-17 grew by 3% in England, more than treble the 0.8% achieved in the wider UK economy, Office for National Statistics data showed. Health service productivity in England also outpaced that of health services elsewhere in the UK: the health service achieved 2.5% growth overall. "These figures are a testimony to the dedication and skill of NHS staff," said Simon Stevens, NHS England chief executive.

Migraine drug is "not cost effective"

Erenumab (Aimovig; Novartis), a new drug for preventing migraine, cannot be recommended for NHS use because it is not cost effective, NICE advised in draft guidance. No evidence found erenumab to be more effective than botulinum toxin type A for people with chronic migraine, which NICE already recommends. Erenumab is listed as costing around £5000 a year, although an agreement with its manufacturer would have made it available at a discount had NICE recommended the drug.

Cite this as: *BMJ* 2019;364:l207

IVF

Three quarters (74%) of women treated in the last two years for infertility had at least one type of treatment add-on, such as an endometrial scratch (27%), embryo glue (23%), or embryoscope (22%) *[HFEA]*

SIXTY SECONDS ON . . . PETER BOGHOSSIAN

MAN CITY'S LATEST SIGNING?

No, he's assistant professor of philosophy at Portland State University in Oregon, but he faces losing his job after helping to create a number of spoof academic papers that were published in peer reviewed journals.

WHY DID HE DO THAT?

He says he was trying to expose politically correct "nonsense" in social sciences. With two colleagues, he wrote "intentionally broken" papers on gender, race, and sexuality.

BUT ISN'T MOST SOCIAL SCIENCE RESEARCH A BIT FLAKY?

One paper that purported to examine rape culture through the study of dogs in a Portland park claimed to have involved the examination of "10 000 dogs' genitals." The paper, published in the journal *Gender, Place, and Culture*, suggested that men should be trained like canines to prevent rape culture.

THAT DOES SOUND A BIT FAR FETCHED

Another paper, "Our struggle is my struggle: solidarity feminism as an intersectional reply to neoliberal and choice feminism," was a rewrite of chapter 12 of Hitler's *Mein Kampf* with feminist "buzzwords switched in." Other papers argued that the science of astronomy is "intrinsically sexist."

THEY FAILED PEER REVIEW, SURELY?

Of 20 papers submitted, seven were accepted by peer reviewed journals. The *Times* reports the spoofs featured "very shoddy methodologies including incredibly implausible statistics" as well as "claims not warranted by the data."

SHOULDN'T HE BE FETED, NOT SACKED?

Portland said Boghossian studied "human research subjects"—the staff and peer reviewers—without proper ethical approval. Another charge relates to data falsification.

DOES HE HAVE ANY SUPPORTERS?

Richard Dawkins, the evolutionary biologist , wrote to the university: "Do your humourless colleagues want Portland State to become the laughing stock of the academic world? Or at least the world of serious scientific scholarship uncontaminated by pretentious charlatans of exactly the kind Dr Boghossian and his colleagues were satirising?"

Jacqui Wise, London Cite this as: *BMJ* 2019;364:l193

A&E: performing better but still missing targets

Taj Hassan (left) warns patient flow is still a problem, and Nick Scriven says problems are becoming "normalised"

Clinical leaders have urged the NHS to renew its commitment to meeting key performance targets after figures showed that the service remained in breach in most areas in England.

NHS England statistics show slightly improved emergency department performance this winter, with 86.4% of patients seen in four hours in December 2018, up from 85% in December 2017. The NHS also saw 3.9% more people within the target time in December 2018 than in the same month the previous year, after extra preparation for winter, plus mild weather, and low flu rates.

But the service continues to be in breach of most key targets. In December 2018, only five major emergency departments met the target to see 95% of cases within four hours. Overall, 79.3% of people attending major emergency departments were seen within the target.

And with the NHS's long term plan containing no information about when the service will get back to meeting statutory waiting time targets, some have questioned NHS England's commitment to them.

The president of the Royal College of Emergency Medicine, Taj Hassan, warned, "With average bed occupancy in December around 91%—an unsafe level—patient flow is still clearly a problem, and we worry that January will be much worse."

Nick Scriven, president of the Society for Acute Medicine, said, "We are now in a situation where targets are perpetually being missed, so it has become normalised. That is dangerous territory."

The King's Fund noted that the NHS was currently missing five out of eight targets for cancer diagnosis and treatment. And the Royal College of Surgeons was concerned that only 87.3% of patients were seen within 18 weeks, meaning the 92% referral to treatment target was last met in February 2016.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l184

A&Es saw 3.9% more people within the four hour target in December 2018 than the previous year

Review calls for new GP business models

GP partnerships in England should be free to operate under different legal models to reduce the personal risk that is putting off many GPs from becoming partners, a government commissioned review has advised.

The independent review, commissioned a year ago to tackle concerns about the sharp decline in GP partner numbers, makes a range of recommendations for strengthening the partnership model, spanning issues such as financial risk, workload, and workforce.

It said ministers should pursue the "significant opportunities" available for reducing personal risk and unlimited liability, including allowing practices under general or personal medical services (GMS or PMS) contracts to provide services under other legal models such as limited liability partnerships (LLPs) and social enterprises. Practices in England holding alternative provider medical services (APMS) contracts can already operate under different legal structures, but the review noted that changes to primary legislation would be needed for a GMS or PMS contract to do the same.

Risks greater than the benefits

The report acknowledged that LLPs may not be the preferred model because of additional requirements to publish accounts and other corporate information. But it said, "The risks of being a partner are now considered by some GPs to be significantly greater than the benefits, particularly in relation to the unlimited liability of the basic partnership model."

It noted the legal uncertainty over issues such as whether a partnership changing its legal structure might be subject to open tendering for existing contracts. To tackle such concerns,

Fired Cochrane director to set up new "integrity in science" institute

Peter Gøtzsche, who was expelled from Cochrane, the leading evidence based medicine group, last year, plans to found a new Institute for Scientific Freedom. The new organisation, whose goal is "to preserve honesty and integrity in science," will be launched on 9 March in Copenhagen.

Gøtzsche (below), who was a member of Cochrane's board until his sacking last autumn, told *The BMJ* that the institute will be financed by crowdfunding. It will focus on lobbying for improvements in healthcare research quality as well as producing its own research.

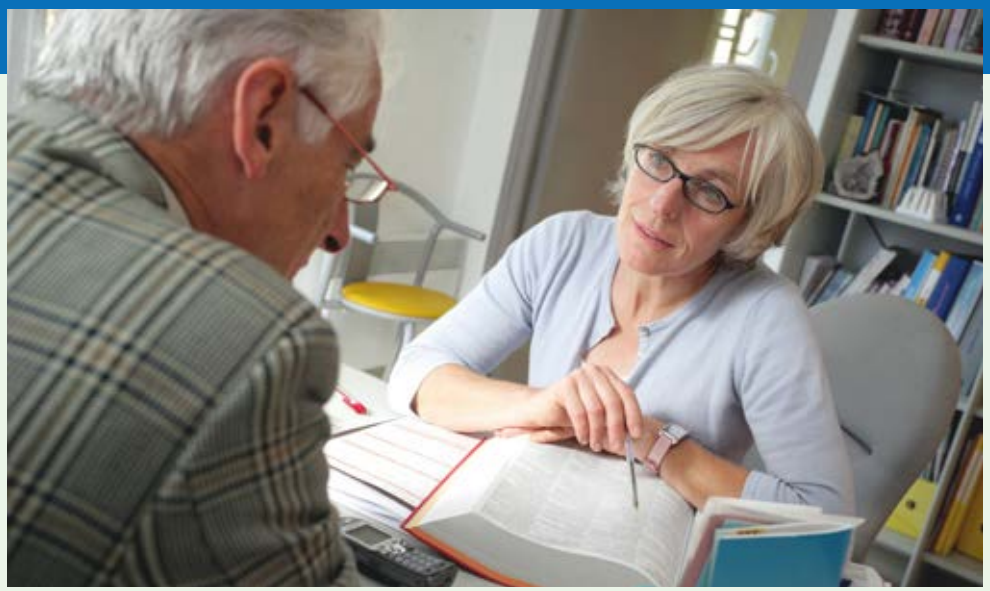
Gøtzsche has previously lobbied the European parliament for improved access to clinical trial data and hopes to continue to do so through the institute. "We have no ambition to rival Cochrane," he said, adding that the idea for the new body came from Peter Breggin, a US psychiatrist and critic of psychiatric drug and shock treatments.

The British epidemiologist Tom Jefferson, whose efforts to uncover unpublished trial data led to questions over the benefits of flu vaccines, will also be involved, Gøtzsche said.

The new institute will have three founding principles, Gøtzsche told *The BMJ*: that all science should strive to be free from financial conflicts of interest; all science should be published as soon as possible and made freely accessible; and all scientific data, including study protocols, should be freely accessible.

Melanie Newman, London

Cite this as: *BMJ* 2019;364:l183



the report urged the government to provide the BMA's General Practitioners Committee with legal advice to help practices understand "the perceived benefits and potential risks of the available options."

To further boost partnerships, the review said that NHS England's ongoing review of premises should seek to mitigate the personal risk associated with being a leaseholder or owner, and provide support and guidance on property ownership.

The review also emphasised the importance of implementing the promised state backed indemnity scheme from 1 April as another mechanism to encourage GPs to be partners.

Nigel Watson, the chair of the review and a GP partner, said in a letter to the health secretary that the recommendations "will address many of the challenges we face, revitalise the valuable partnership model, and make general practice a great place to work once again."

In response to the review, Richard Vautrey, chair of the BMA GP Committee, said it was vital that the partnership model was given "greater support to ensure its survival."

"The proposals will make general practice a great place to work again"
Nigel Watson, review chair

He added, "The report rightly notes the pressures placed on GP partners and the growing risks and liability they carry, and it is therefore imperative the government takes these seriously."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l222

RECOMMENDATIONS

- Reduce the personal risk and unlimited liability currently associated with GP partnerships
- Fund more GPs and develop new career opportunities
- Increase the capacity and range of other healthcare professionals in the community
- Refocus training to increase time in general practice to enable better understanding of GP partnerships
- Establish and operate primary care networks to improve practices' sustainability
- Ensure that general practice has a strong voice at a system-wide level
- Help practices use resources more efficiently by ensuring access to essential IT equipment and innovative digital services

OTHER AWARDS

- ANTHEM, the insurer, for announcing it would refuse to pay for emergency visits if the problem was later deemed not to be an emergency
- NURSING HOMES that administer expensive rehab treatments to patients in the final days of their lives
- SAN FRANCISCO GENERAL HOSPITAL, for billing a family $18000 for a brief emergency visit after their baby had a minor bump on the head
- HENNEPIN COUNTY MEDICAL CENTER, Minnesota, for testing antipsychotics and ketamine on patients without their consent

Greediest players in US healthcare "honoured"

A drug company topped a list of the worst actors in US healthcare for the second year in a row, but other sectors—such as hospitals, physicians, and insurers—gained ground in the second annual Shkreli Awards.

"This year we quite intentionally cast a wider net than just the well known and insane greed of the pharmaceutical sector," Vikas Saini, president of the Lown Institute, an advocacy group that bestows the awards, told the *The BMJ*. "We wanted to make the point that profiteering has become rampant and is not confined to any one particular sector of the healthcare enterprise."

Three of the 10 spots in this year's awards went to drug manufacturers, double the five in the inaugural awards last year. The awards were named after the former Turing Pharmaceuticals executive Martin Shkreli, widely reviled for sharply increasing the price of generic pyrimethamine for toxoplasmosis.

Profits first

This year's top spot went to Nostrum Laboratories' chief executive Nirmal Mulye, who justified his company's 400% price hike of a liquid formulation of nitrofurantoin, a generic antibiotic that treats bladder infections, telling the *Financial Times* that there was "a moral requirement to sell the product for the highest price" in order to reward shareholders.

The company didn't respond to requests for a comment.

Second place went to the Michigan oncologist Farid Fata, who prosecutors said administered harmful chemotherapy treatments to at least 553 patients who did not actually have cancer. Fata was sentenced to 45 years in prison but later claimed that he was coerced into giving a false guilty plea, according to the *Detroit Free Press*.

Third place went to AbbVie's Pharmacyclics and to Johnson and Johnson's subsidiary Janssen, which tripled the price of the blood cancer drug Imbruvica after introducing it in a new, single tablet version.

Mary Chris Jaklevic, Chicago

Cite this as: *BMJ* 2019;364:l188

"A MORAL REQUIREMENT TO REWARD SHAREHOLDERS" NIRMAL MULYE, NOSTRUM LABORATORIES

Genome sequencing of children promises new era in oncology diagnosis and care

All children with cancer in England will be offered whole genome sequencing from this year in a move that will enable more comprehensive and precise diagnosis and access to more personalised treatments.

NHS England's long term plan says that this will reduce the use of harmful drugs and interventions, increase access to clinical trials, and reduce the number of young patients who have health problems caused by chemotherapy and radiotherapy.

The small numbers—around 1800 paediatric cancers are diagnosed each year—means it is more feasible to offer whole genome sequencing to all children rather than all adults with cancer. However, adults with certain rare conditions or specific cancers will also be offered full genome screening. NHS England says that by 2029 more than 100 000 people a year will be able to access the tests.

Aine McCarthy, from Cancer Research UK's children's cancers team, said that the announcement was very exciting. "It will give us a load of new information about how these cancers start and how they grow, and will hopefully help us develop new treatments," she told *The BMJ*. "It's not always about new drugs: it's also about using the drugs we already have in the best way."

Information about specific genetic mutations can also help direct children to appropriate clinical trials of existing targeted treatments, she said.

Three major benefits

Darren Hargrave (above), honorary consultant paediatric oncologist at Great Ormond Street Hospital for Children and a member of the paediatric cancer task group that advised NHS England, said that there were three major benefits of genomic testing in children: precision medicine, refinement of diagnosis, and screening family members.

GETTY IMAGES

"You may be able to give less of a certain type of chemotherapy"
Darren Hargrave, Great Ormond St

Precision medicine—matching a specific mutation to a specific drug—is the area that tends to get the most publicity. Hargrave said that this did occur but only in a small percentage of childhood cancers and usually as part of a clinical trial.

"For example, the BRAFv600 mutation was found a number of years ago in melanoma, but we have started to find it in different paediatric tumours, including brain tumours," he told *The BMJ*. "We have done a number of studies which show that existing drugs for melanoma that target this mutation also work in children with this mutation.

"In most cases in paediatric cancer we end up repurposing drugs for an adult pathway in children." For example, alterations in the ALK gene are found in lung cancer in adults but also in a number of children's cancers. A drug targeting the gene, crizotinib, has been shown in clinical trials to be effective in children with a type of lymphoma.

"The pathway is more important than the site of the tumour," says Hargrave.

Refining the diagnosis

The second major benefit of whole genome sequencing is in refining a diagnosis, because there are many different subtypes in childhood cancer. Molecular testing already exists, and centres such as Great Ormond Street already carry out

BY 2029 more than **100 000** people a year will be able to access these tests, according to NHS England

sequencing of targeted sections of the genome. Sequencing the whole genome will help to refine the diagnosis still further.

"This can help with the prognosis and with conventional treatments," said Hargrave. "For example, you may be able to give less of a certain type of chemotherapy, depending on the risk stratification."

This is particularly important for children because it can help reduce the long term side effects of chemotherapy, which can affect fertility or growth.

Thirdly, testing a child's germline DNA as well as the tumour can help discover whether a child has an underlying genetic predisposition to cancer. This information can be useful to find out whether others in the family may be at risk, said Hargrave.

New treatments

Genome sequencing may also help inform which patients in the future will benefit most from innovative treatments such as CAR-T cell drugs, which work by modifying T cells from the patient's own immune system.

"Immunotherapies have been revolutionary in some adult cancers and shown a lot of promise in children's cancers. The difficulty is knowing which patients should get them," said McCarthy.

In September the NHS struck a deal with Novartis to make the CAR-T cell drug Kymriah (tisagenlecleucel) available to a small number of children with leukaemia.

It was also announced that children who need proton beam therapy will be able to access it in England rather than having to travel abroad. New proton beam facilities have been commissioned in London and Manchester and will come online in the next couple of years.

Kate Collins, chief executive of the Teenage Cancer Trust, welcomed the announcements: "The pledge to record the DNA of every child with cancer to develop personalised treatment is an important and bold step, and the move to increase the number of young people accessing clinical trials could be game changing."

Jacqui Wise, London

Cite this as: *BMJ* 2019;364:l105

"Doctors should take greater ownership of the air pollution problem"
Stephen Holgate, RCP

UK sets target to halve the number of people exposed to toxic air in 10 years

The government's new Clean Air Strategy aims to tackle air pollution from a wide range of sources and includes an ambitious new target to reduce fine particulate matter in line with World Health Organization guidelines.

Ministers say the targets go far beyond existing European Union requirements and make the UK the first major economy to adopt air quality goals that are based on the WHO recommendations. The plan has been broadly welcomed, although environmental campaigners say it lacks detail.

Ambitious targets

The strategy says that fine particulate matter ($PM_{2.5}$) will be reduced everywhere so that the number of people living in places with concentrations above the WHO recommended limit of 10 µg/m^3 will be halved by 2025, from 2016 numbers. The UK already meets the EU limit of 25 µg/m^3 and is on track to meet the second stage limit of 20 µg/m^3.

The government said the plan will set a "new, ambitious, long term target to reduce people's exposure to fine particulate matter" and that it will publish evidence early this year on what action would be needed to meet the WHO annual mean guideline limit of 10 µg/m^3. It will shortly bring forward an environment bill that will include primary legislation on air quality.

The government will also develop a personal air quality messaging system to inform the public about the air quality forecast. In addition, the effects on health of poor air quality will be included in medical education and training programmes. New guidance will be developed to help doctors and nurses advise patients on air pollution.

The strategy said that vehicles were not the only source of harmful emissions and that air pollution came from several sources, including wood burning stoves, small industrial sites, and manure spreading on farms. Burning wood and coal in open fires and stoves makes up 38% of the UK's primary emissions of fine particulate matter. New legislation will be introduced to ban the sale of the most polluting fuels, and only the cleanest stoves will be available for sale by 2022. The government is also consulting on phasing out the sale of traditional house coal and on limiting the sale of wet wood.

Extra strain on NHS

The strategy also includes action to reduce air pollution from agriculture, which is responsible for 88% of ammonia emissions.

England's health and social care secretary, Matt Hancock, called air pollution "a health emergency." He said, "Air pollution causes around 36 000 deaths each year and puts extra strain on the NHS through increased incidents of heart disease, stroke, lung cancer, and child asthma."

The government said that the measures set out in the strategy will cut the health costs of air pollution to society by £1.7bn every year by 2020, rising to £3.5bn a year from 2030.

Stephen Holgate, the Royal College of Physicians' adviser on air quality, welcomed the goal to tighten up the limit for particulate matter and the recognition of multiple pollutant sources. He also endorsed "the view that health professions should take greater ownership of the air pollution problem as they have done with smoking."

Jacqui Wise, London

Cite this as: *BMJ* 2019;364:l210

The government calculated that the measures set out in the strategy will cut the health costs of air pollution to society by £1.7bn every year by 2020, rising to £3.5bn a year from 2030

MATT WRITTLE

THE BIG PICTURE

Friendship: a ticket to a healthier life

"The Fish Friday Ladies"—Pat, Sheila, Geraldine, Joyce, and Marian—make their weekly Friday bus trip into High Wycombe to go shopping and have a spot of lunch at their favourite fish and chip cafe.

This portrayal of their friendship is just one in a series of 40 images captured by the photographer Matt Writtle that were commissioned by the Royal Society for Public Health and the Health Foundation. Taken in the Buckinghamshire town of Chesham, whose district is ranked one of the top 10 healthiest places to live in England, the aim was to build public and political understanding of just how much of what makes us healthy sits outside healthcare.

"It is so fundamentally important that people have access to other human beings, because the key to health is community," says Writtle, whose work focuses on the factors that influence public health, from money and employment to housing and community networks.

Despite its healthy reputation Chesham has pockets of deprivation and significant health inequalities: the least affluent wards, Vale, Ridgeway, and St Mary's and Waterside, have a life expectancy nine years lower for men and six years lower for women than the most affluent.

Other images in the series show the local market, football team, and a community group called the "Pond Park Over 30s People's Group" (PPOP In), where the Fish Friday Ladies originally made friends.

See all the images from the Healthy Lives Photography Commission at http://bit.ly/2HfwnJS.

Rebecca Coombes, *The BMJ*

Cite this as: *BMJ* 2019;364:l220

EDITORIAL

The hidden power of corporations

A lesson from China

Mao Zedong once said that "political power grows out of the barrel of a gun."[1] Yet power can be exerted in different ways and can be most effective when it is hidden, with decisions made behind closed doors, so that the decisions one person makes are influenced by another without them realising it.[2]

The growing literature on what are termed "the commercial determinants of health" pays particular attention to invisible forms of power, whereby large corporations use various methods to shape thinking about appropriate responses to the health consequences of their products.[3] In her article (see p 110), Susan Greenhalgh describes how the Coca-Cola company came to dominate Chinese obesity policy even as its influence was obscured behind the public face of intermediaries.[4]

Changing the conversation

In the late 1970s, Coca-Cola took advantage of the opening of Chinese society, exploiting the then extremely limited opportunities for Chinese researchers to access funds to undertake studies or to develop links with Western counterparts. It was not, however, Coca-Cola that made the approaches to Chinese researchers. Instead it was an organisation called the International Life Sciences Institute—a name that combined ideas of health, academia, and international links while also forming a memorable acronym, ILSI. Yet ILSI was established by a Coca-Cola executive with substantial funding from the company.

As Greenhalgh describes, the ILSI "Focal Point in China" (ILSI-China) has been able to exert remarkable influence on development of obesity policy by promoting a narrative that all foods and drinks, including those produced by Coca-Cola, could be part of a healthy diet. What matters, it claims, is that individuals expend the calories they ingest by taking sufficient exercise. This too was the message of the Global Energy Balance Network, also set up by Coca-Cola and with members well represented at ILSI supported Chinese conferences. Coca-Cola had viewed the network as a "weapon" to "change the conversation" about obesity to one that diverted attention from its products in a "war between the public health community and private industry."[5]

Companies use third parties to create a dominant narrative that excludes effective measures that harm their interests

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We now know corporations make extensive use of third parties such as ILSI to create a dominant narrative that frames how issues are viewed and sets the boundaries within which responses are seen as "reasonable," while excluding the most effective measures—especially those that harm their interests—from the agenda.

Some have specific goals, such as the Center for Indoor Air Research, which sought to undermine the evidence on the dangers of secondhand smoke.[6] Others use a broader approach that includes promotion of individual choice over collective action, supporting often ineffective educational campaigns rather than regulatory measures that tackle price, availability, and marketing of their products.[7] This is exemplified in the use of the term "nanny state" to attack many of the most effective public health measures.[8] The approach also emphasises the "complexity" of public health problems, implying that little can be done to tackle them, applying the same language to issues as diverse as junk food, gambling, and asbestos.[9]

This approach also downplays potential conflicts of interest. Industry funded reports contend that everyone is in some way conflicted—for example, in holding certain political views—and that as long as funding is declared any conflicts are easily managed. If everyone is conflicted, there is no cause for concern.[10] Yet a wealth of evidence shows that industry funded studies tend to reach conclusions favourable to sponsors[11] and that disclosure of funding alone is inadequate, as researchers may exaggerate their findings and reviewers discount the potential for bias.[12]

ILSI's activities in China are similar to those it pursues elsewhere, which have long raised concerns. In 2001 a World Health Organization report condemned its links to the tobacco industry.[13] A 2002 paper described ILSI's involvement in research as a "threat to scientific integrity."[14] Yet, despite this information being freely available, ILSI's 18 constituent bodies remain influential around the world.

Changing attitudes

There are, however, signs that attitudes are changing. Recently, the food company Mars pulled out of ILSI, noting concern about its "advocacy led studies" that "mostly for the right reasons, have been criticized."[15] The Philip Morris funded Foundation for a Smoke Free World has attracted much adverse comment,[16] and many universities and public health associations have stated they will not accept funding from it. The UK Charity Commission is questioning the status of think tanks that actively support the narrative of corporations[18] but refuse to publish funder details.[19]

Yet, as the heavily criticised partnership between Public Health England and the alcohol industry funded Drinkaware shows, this message has not reached everyone.[20]

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EDITORIAL

The NHS long term plan and public health

An opportunity to create a unifying "national service for health"

The new NHS long term plan for England is rightly ambitious and sets out a vision that is largely technocratic and pragmatic, and ostensibly dogma-free.[2] The plan comes in a time of deepening austerity, widening health inequalities, and deep cuts in local government and public health budgets.[3] Although it looks like a good plan for the NHS, is it a plan for health, wellbeing, equality, and care?

There is considerable expectation that demand for services can be reduced through prevention, with an emphasis on delivering targeted interventions to reduce risks. The NHS will offer hospital tobacco treatment services to all smokers admitted to hospital and will offer weight management programmes to obese patients with type 2 diabetes or hypertension. The national diabetes prevention programme will be expanded. Hospital food standards will be improved, as will nutrition training for medical professionals. Hospitals with high rates of admissions related to alcohol dependence will have specialist alcohol care teams.

Efforts to tackle antimicrobial resistance will continue. The NHS will take steps to reduce inequalities in access to care and in outcomes.[4] Action will be focused on vulnerable groups, including mothers from deprived communities, people with severe mental illness, people with learning disabilities and autism, carers, rough sleepers, veterans, and people with serious gambling problems.

Public health priorities elsewhere in the plan include improving outcomes for mothers and babies, better mental health services for children and young people, suicide prevention, and cancer prevention through screening and expanding HPV vaccination to boys.

The NHS cannot answer all societal ills. But the plan acknowledges this and seeks to contribute what is within its compass. This is the first time an NHS plan has acknowledged any responsibility for reducing health inequalities. The plan recognises the vital role of the NHS as a good corporate citizen, as an anchor employer for the local economy and in its contribution to climate change. It is weak on harnessing community resources but does acknowledge the role of social enterprises, patient involvement in healthcare and health policy, and social prescribing.

This is the first time an NHS plan has acknowledged responsibility for reducing health inequalities

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Implementation

As others have commented,[2] successful delivery remains the plan's biggest challenge. Meaningful progress demands genuine partnership with local government and a clear commitment to more funds for public health budgets. Uncertainty has been created around NHS involvement in services currently under local authority control, including sexual health, health visiting, and school nursing. The problem is inadequate funding not local government commissioning.[7,8]

Top-down initiatives such as diabetes prevention add cost pressures to already stretched local public health services and lack joint planning. However, an expanded acknowledgement of NHS responsibility for prevention is welcome and should bring opportunities for joint commissioning and investment. Strong, properly funded community involvement will be central to successful implementation.

We need expanded capacity in population health management and public health skills,[9] in NHS workforce planning, and in training budgets. Public health expertise has been lost since it moved to local government. Critical and independent analysis of wasteful healthcare spending has also been lost and must be regrown.

Governance of the NHS's role in prevention and reducing inequalities needs to be refined. There is a need for specialist public health expertise in all NHS institutions.[9] A "dashboard" for interventions on inequalities is also needed to track progress. Only during the 2000s was health inequality successfully reduced, when social policies were combined with systematic secondary prevention and overseen by the Department of Health inequalities unit.[10]

The secretary of state can only deliver his vision for prevention[11] by securing more investment in local government public health and in social care.[12,13] The return on prevention investment is clear.[14] Without whole system investment, genuine partnership, and joint planning, this NHS plan will fail, as so many have before. A prevention transformation fund would re-energise local authority public health and restore confidence that local authorities are key partners in improving the health and wellbeing of the people they serve.[15]

Critically, the government must also show its plans take full account of health in all policies—housing, industrial and transport, food and agriculture, welfare rights and taxation.[3] The health of the people should be the highest law. There is a rare opportunity here to create a "national service for health" in the next 10 years. Let's not squander it.

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PENSIONS

Cuts to pension tax relief deepen senior doctor retention crisis

MALCOLM WILLETT

Doctors' fears about income after retirement feature prominently in the decision to take early retirement, a BMA survey shows. **Stephen Armstrong** explains the issue

A BMA survey published last week shows that six out of 10 consultant doctors (2446 out of 4089 respondents) are intending to retire from the NHS before or at the age of 60. The second biggest factor for this decision, after work-life balance, is pension legislation.

The survey also found that more than a third (36%) were expecting to reduce the number of days they work in the NHS by up to half. More than 40% said they have stopped or intend to stop taking part in initiatives to reduce waiting lists.

"There aren't enough doctors in any specialism as it is," argues Rob Harwood, chair of the BMA Consultants Committee, and an anaesthetist. "We expect that in 15 years we'll have 25% too few anaesthetists, and having spoken to other colleges I think that's about average [for all specialties]—no one is saying they have enough people. Consultants are the most experienced members of a team—the most experienced, most efficient, and most cost effective."

Huge tax bills

This pension pressure on senior doctors has been caused by a recent change to regulations that means many consultants are receiving huge tax bills and that these increase significantly if they work harder. "Pension legislation has been changing—and deteriorating—for higher earners for years," says Andrea Sproates, head of Chase de Vere Medical, one of the UK's largest independent financial advisers.

"Previously only a doctor's NHS pensionable income mattered. Now we have to look at every piece of taxable income—NHS work, private work, dividends, rental income, earnings; all combine with salary to determine income. We're also seeing the effects of tapering on annual allowances introduced in 2017. So many people who don't understand it get caught unawares."

The problem is caused by changes to the annual allowance, a threshold which restricts the amount of pension growth people are allowed each year before tax charges apply. When pension growth exceeds the allowance the charge is intended to recover tax relief on pension contributions.

When it was first introduced in April 2006 the annual allowance was set at £215 000, increasing each year until 2010-11, when the government sharply reduced the threshold from £255 000 to £50 000. The following year, it was reduced further to £40 000 and, in 2016, tapering for high earners was introduced. This means the threshold falls the more you earn.

Those with a taxable income over £110 000—including all earnings inside and outside the NHS—will have their annual allowance for that tax year restricted. For every £2 of income they have over £110 000, their annual allowance is reduced by £1, with a maximum reduction of £30 000. So consultants with an income of £210 000 or more will have an annual allowance of £10 000. This means paying tax on any growth to their pension pot above £10 000 in the tax year April to April.

Public sector disadvantage

In theory, this allowance applies to all pensions in the UK. In practice, the two main types of pensions—defined benefit and defined contribution—experience this threshold differently. Defined contribution schemes invest individual members' contributions, as well as their employers', in different investments without guaranteeing a final level of pension income. Defined benefit pensions—sometimes final salary schemes, sometimes career average revalued earnings—pay a pension based on the member's earnings and the length of membership in the fund. The BMA estimates that 90% of defined benefit schemes are in the public sector, but freedom of information requests to HMRC have produced no response.

With defined contribution schemes, pension growth comes from the employee, employer, and tax relief, as well as growth in the investments selected. With defined benefit pensions, the employee's pension grows through employee and employer contributions only. In the NHS, this is typically 14% of a doctor's salary—and the employee has no option to reduce contributions without quitting the scheme.

"Generally speaking doctors qualify then work their whole career in the NHS and are members of the NHS pension scheme," Harwood explains. "As it is a defined benefit scheme, coupled with their long service, their earnings in many cases put them in the danger zone. We estimate that any doctor earning over £70 000 with protected benefits is likely to be affected, although the whole process is so obscure and complicated that it's hard to get a full picture."

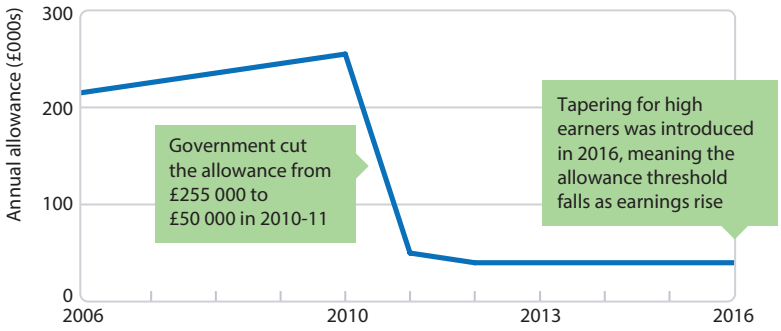
According to NHS figures, from 1 October 2018, consultants working in the NHS earn a basic salary between £77 913 and £105 042 a year depending on their length of service. According to the GMC there were 72 024 specialists or consultants working in the NHS in 2017.

One political NHS lobbyist recalling a 2015 meeting at the Treasury said a senior minister told him, '"If you want to catch a lot of people in a tax trap you make it more complex. If you want to catch even more, make it more complex still.' That's exactly what the government has done."

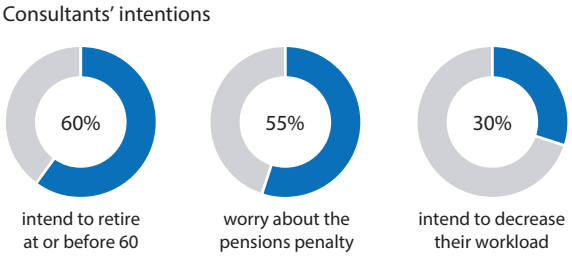
The BMJ spoke to three hospital consultants who had been caught unawares by the complexity of this tax, although they preferred not to be identified. One received an unexpected tax bill of nearly £100 000 and has since left the NHS to focus on private practice. The others both had bills of £30 000 or more arriving out of the blue. "The problem is," said one, "If I take on more work to pay off this bill, that increases my income and so reduces my allowance further, landing me with a larger tax bill. I don't have that kind of money, so I am going to have to borrow £20 000 to meet this year's bill. It's a trap."

"Doctors would be off their chump if they started taking on extra work. I'm not surprised the fallout of these taxes is demotivation"
Doug Mullen, solicitor

"Doctors are uniquely placed," says Doug Mullen, senior associate at solicitors Anthony Collins. "They would be off their chump if they started taking on extra work, so I'm not surprised the fallout of these taxes is demotivation."



Changes to the annual allowance for pensions



Consultants' responses to BMA survey, based on 4089 replies

Perverse incentives

"Such a situation is clearly untenable," Harwood argues. "During a deepening workforce crisis, the NHS needs its most experienced and expert doctors more than ever. I struggle to understand how the health secretary can talk about increasing productivity in hospital care while allowing the NHS to be a system which perversely encourages its most experienced doctors to do less work and, in some cases, to leave when they do not want to. This is happening against the backdrop of the derisory new pay settlement for consultants in England—an average weekly uplift of just £6.10 after tax—when they have lost over 24% of take home pay in the past decade."

In August 2018, Chase de Vere Medical said it had noted a "significant increase" in the number of doctors either stopping contributions into the NHS pension scheme or retiring early. The pension tax arrangements are also driving GPs out of the NHS, according to the Royal College of GPs (RCGP). "We are desperately short of GPs across the country, and we need to explore all possible options to retain our hard working and experienced workforce," says Helen Stokes-Lampard, chair of the RCGP.

"Measures to keep GPs in the workforce longer, including removing incentives to retire early, would both be sensible places to start."

In August 2018 and again last week, the BMA raised its concerns directly with the government, warning that reductions in tax relief would lead to doctors facing additional tax charges of tens of thousands of pounds. The BMA has also written to Matt Hancock, England's health secretary, to offer solutions and ask for a reconsideration of the annual allowance and a guarantee that doctors who leave the pension scheme can have their employer's allowance paid into a private scheme.

To date, the association has received no answer, although Hancock said in an interview last week that he was considering offering GPs more generous pensions in a bid to stop them leaving the health service early. "The biggest concern I have raised with me is around the tax treatment of pensions," he told GP magazine *Pulse*. "I've had conversations with the chancellor about looking at the details of tax treatment of pensions because I understand the impact that that has."

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"The only thing worse than having politicians is not having politicians"

Northern Ireland's two years without a government is affecting healthcare, from lengthening waiting lists to staff shortages and hospital reform, finds **Niamh Griffin**

Northern Ireland has been without a government since the collapse of a coalition in January 2017; one doctor says wryly that, in the two years since, the profession has learnt that the only thing worse than having politicians is not having politicians.

In September, Westminster's Northern Ireland secretary Karen Bradley cut the pay of the devolved Northern Ireland Assembly's elected members, in an effort to pressure them to conclude power sharing talks and return to work—but there is still no resolution in sight (see box).

"If doctors failed to turn up for work, they would stop paying us," says Tom Black, chair of the BMA's Northern Ireland General Practitioners Committee. "If politicians are failing to work at their profession, there should be sanctions."

Health policy experts, doctors, and other healthcare professionals warn of a "huge hiatus in health" as a result of the power vacuum in Stormont.

Spiralling waiting lists

Waiting lists in Northern Ireland are substantially worse than in the rest of the UK, and many blame the lack of ministers. "Waiting times are appalling," says Deirdre Heenan, professor of social policy at Ulster University and member of the Council of State in the Republic of Ireland. "If the assembly was sitting and a health minister was being asked every day about these numbers, then eventually he or she would have enough and start working on a fix. That is not happening."

Department of Health figures as of September 2018 show 94 222 people in Northern Ireland waiting longer than 52 weeks for their first consultant led outpatient appointment; equivalent statistics for England show 3464 waiting, from a much larger population.

It is a concern for clinicians in every field, Black says; a patient referred by a GP for a hip replacement, for example, can expect to wait up to five years for the operation.

There has been a marked increase in prescriptions for opiate patches to manage pain as a result, he says. Black, a GP in Derry, adds that one of his patients is travelling to Lithuania for treatment; he's also seen families club together to fund private care for relatives.

Rita Devlin, deputy director at the Royal College of Nursing, sounds a note of warning about linking the lack of ministers to waiting lists: "We have huge waiting lists, but it's hard to say if it's a direct result of not having a minister. We had waiting lists before, when we had a minister."

But, she adds, "The question, now, is who is accountable? There is no one responsible for waiting lists, and they are the worst in the UK."

Stalled reform

Heenan agrees: "The question is: who is making decisions on radical change?" It's a question being asked across the hospital sector, which was promised system-wide reform after a sweeping review of hospital care carried out in 2016.

"The question is: who is making decisions on radical change?"
Deirdre Heenan, professor of social policy at Ulster University

"Even though some projects are still going on, the big ticket items have stalled"
Mark Taylor, consultant general and hepatobiliary surgeon at the Mater Hospital

The Systems Not Structures review—by Rafael Bengoa, a Spanish expert in public health management—called for strategic planning to shift away from constructing new buildings to developing existing services.

Launching a reform plan based on the Bengoa review in October 2016, health minister Michelle O'Neill said, "The system itself is at breaking point. We face a number of challenges. The way services are organised is constraining transformation."

Four months later, the assembly fell.

Mark Taylor, consultant general and hepatobiliary surgeon at the Mater Hospital, Belfast, was on the independent expert group advising Bengoa. It would be wrong to say the whole health service is stagnating as a result of the political hiatus, he says, because some projects planned before the government collapse have continued.

He points to the opening of two elective care centres in Omagh and mid-Ulster as examples of this: "The hope is that by ramping up other services we can have a beneficial impact on hospital capacity."

Taylor adds, however, "The political will has to be there to reform services. Even though some projects are still going on, the big ticket items have stalled."

Black agrees: "We can keep on making incremental changes, but there will be no big hospital closures or movement without buy-in from all political parties."

The pay of Northern Ireland Assembly members has been cut but there is still no sign of them returning to Stormont

"Any decision likely to be controversial or lead to big change is not being taken. So there is stagnation"
Seamus McAleavey, Northern Ireland Council for Voluntary Action

"There is no one responsible for waiting lists, and they are the worst in the UK"
Rita Devlin, deputy director at the Royal College of Nursing

Awaiting ministerial decisions

This is a particular concern for emergency and urgent care, says Paul Kerr, emergency medicine consultant at the Royal Victoria Hospital, the largest emergency department in the region. "The health department is planning work to look at how emergency and urgent care can be improved, but any recommendations would be subject to ministerial approval," he says. "So people are doing work that cannot bear fruit until we have a minister."

Kerr, also vice chair of the Royal College of Emergency Medicine in Northern Ireland, adds: "People use emergency departments more per capita in Northern Ireland than in any other part of the UK. There are plans to treat patients in the community, but many of the decisions to implement change in the acute system await ministerial decisions."

"It is not OK to go on like this. But workforce planning is something that should be headed up by a minister"
Tom Black, chair of the BMA's Northern Ireland General Practitioners Committee

To those looking on from the community sector, the stalemate means an ongoing focus on hospitals instead of patient centred reform. The Northern Ireland Council for Voluntary Action lobbies for voluntary groups and provides services to support them in their work. The council's chief executive, Seamus McAleavey, says, "The Bengoa report said to forget about location, that we need to reorganise services. I don't see that happening."

Stroke services were another sector targeted for reform, but Neil Johnston, policy analyst with Northern Ireland Chest Heart and Stroke, echoes his colleagues' concerns.

"I would say reforms were urgently needed. The configuration for services is outdated—that is our big problem. We have too many emergency departments. There are eight hospitals admitting patients with stroke related symptoms, and the experts say we only need three."

Johnston says reform of how thrombectomy patients are referred for treatment began before the government collapsed. This was driven by clinicians and neuroradiologists offering a 9 am to 5 pm service. But the hoped for next phase of 24 hour delivery can't happen without ministerial sign-off, Johnston says. "Grassroots projects like that in thrombectomy are going ahead but the big ticket items, like staffing redeployment, are not happening."

Budget rollover

He adds: "The health budget in Northern Ireland has been relatively protected so this is not a problem with money. It's about leadership—from NHS trusts, but also politically."

McAleavey agrees, saying: "Any decision that is likely to be controversial or lead to big change

STORMONT'S COLLAPSE: WHAT, WHO AND WHY

The devolved Northern Ireland Assembly was governed for a decade from 2007 by a power sharing agreement between nationalist and unionist parties. One of the main causes behind the collapse of this coalition, in January 2017, was disagreement over the "cash for ash" scandal.

A scheme set up for environmental reasons did not have a payment cap—unlike in the rest of the UK—meaning companies were effectively incentivised by the state to waste fuel and receive grants for this.

Arlene Foster (Democratic Unionist Party, far left), minister in charge at the time, was first minister of the government when news of the scandal broke, but declined to step aside during investigations.

Deputy first minister Martin McGuinness (Sinn Féin, left) resigned in protest. An inconclusive election followed, and months of talks since have failed to achieve agreement among the political parties.

is not being taken. So there is stagnation." He points to the annual health budget, saying it is now rolling over from year to year without change, describing the situation as "flat cash."

This is a particular problem in mental health, says Heenan. It's an area that needs change, and is of great importance in Northern Ireland because of the impact of years of trauma. "Mental health is an area in need of funding, but they are still working on the old budget," Heenan says, "it's all simply rolling over."

However, Conor McCafferty, from mental health charity Zest: Healing the Hurt, points to initiatives that have continued precisely because the ringfenced overall health budget of around £8m continues to be available. Projects such as the street triage pilot, in which a community psychiatric nurse partners with police to answer call-outs that could be related to mental health problems, have continued, he says.

Plans for a new suicide prevention strategy, Protect Life 2, have stalled, though. "There isn't a formal document that outlines or informs the public of changes, and this has understandably caused some anxiety," says McCafferty.

Paula McComish, spokesperson for the Department of Health, says: "To date, the department has been unable to publish the Protect Life 2 strategy without ministerial endorsement. Publication of the finalised strategy would, of course, be beneficial, however, it would be wrong and totally misleading to suggest that support for those who need it is being compromised because of any delay."

Staff shortages

The stagnation of hospital reform because of a lack of political leadership is reflected, Black says, in decreasing numbers of junior doctors applying for training.

Shortages are also a problem for nursing, says Devlin, in part because the crisis is hitting nurses and some allied health professionals in their pockets.

Pay awards made in other parts of the UK early in 2017 were only paid in Northern Ireland in November that year. The latest pay offer made by the Northern Ireland Department of Health is only for one year, in contrast with other UK nurses who received a three year deal. "We are now the lowest paid nurses in the UK," Devlin says. "There are background negotiations going on but, now that there is no health minister, there is no one to sign off.

Civil servants now have wider powers to take action in the absence of ministers

"We have detailed plans for changes to national pay structures but there is no minister driving that now. This is frustrating for our nurses. For example, my electricity bill is 13% higher than last year's, but nurses' wages are not matching those increases."

Staffing for hospital emergency departments is a key worry arising from the stalemate for Kerr. "One of our most pressing problems is a shortage of nurses in our region," he says. "They are paid less than colleagues in the rest of the UK. We are unable to recruit staff to very pressurised units, or to open beds sometimes."

Devlin adds: "This is about more than pay—it's a lack of value given to the work done by nurses. As professionals, people are asking if they are valued."

This is a question also raised by staff in community care, including those in general practice. GP Black says the field is suffering from lack of direction as a result of the power vacuum, adding to legacy problems caused by lack of investment in this sector in the past. In just one county, Fermanagh, 18 practices have reduced to just eight in two years.

"Grassroots projects are going ahead but the big ticket items, like staffing redeployment, are not"
Neil Johnston, policy analyst with Northern Ireland Chest Heart and Stroke

"This is an extraordinary thing to happen," says Black. "Three or four practices have been merged into one because there just aren't enough GPs, and patients are making long journeys when medicine should be local.

"It is not OK to go on like this. But workforce planning is something that should be headed up by a minister. "

Civil servant solution?

In response to growing frustration with the political delay, secretary of state Karen Bradley brought in legislation in November that aims to give wider scope to civil servants' decision making powers: the Executive Formation and Exercise of Functions Bill. This should mean civil servants can take action without needing ministerial sign-off, but it's not yet clear what this means for health reform.

Department of Health spokesperson McComish says: "The department is continuing to review all policies and strategies on a case by case basis and taking decisions, with legal advice, when it is in the public interest or there is a countervailing legal duty to do so." Safe services are the priority, she says.

McAleavey doubts the wider powers will result in the radical reform needed. "Civil servants are from a different background to politicians, they are cautious and make safe decisions. They are not a bunch of mavericks," he says.

"There is also a wider matter here: decisions affecting citizens should be taken by elected officials—they have the mandate. There are questions about legitimacy."

The overall feeling is one of pessimism. "There is a huge hiatus in health—that's what it feels like," says Devlin. "It would be wrong to say no progress is being made, but there is a vacuum.

"The impact is on citizens; we're nurses but also citizens. Patients are citizens, too, and they are waiting on treatment for themselves, their parents, or grandparents. Delays are impacting on everyone's life in one way or another."

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