

# this week

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## BMA expenses exposé sparks review

**EXCLUSIVE** The BMA has come under fire from its council members after it emerged that—until the practice was stopped earlier this year—senior officers had been taking spouses with them on trips abroad and reclaiming the costs as expenses, although the BMA had no formal policy to permit it.

During this period the only senior officer officially allowed to be accompanied by his or her partner to some events and to claim for the associated costs was the BMA president. However, it recently became apparent that others were also reimbursed for spousal travel expenses in this way.

Chaand Nagpaul, who has been chair of the BMA's council since 2017, instituted a ban on such expense claims after he became aware of them in January. He is now planning a wider review of the association's governance.

The scale of the payouts is not yet clear. *The BMJ* has been told that none of the current chief officers have been in receipt of such payments and all previous beneficiaries have since left the association.

Doctors on the BMA's council had raised concerns about the payments, arguing that such largesse was wrong at a time when rank and file members, including junior doctors and medical students, were coping

with pay rises below inflation. A letter signed by around a dozen council members was sent to the BMA's governing board in March asking whether directors intended to seek repayment from the beneficiaries.

Nagpaul said, "There are understandably strong views that monies paid in this way should be reclaimed." He added that the BMA has been advised that there was no legal obligation to repay, but he would be writing to those involved.

Council members Sam Everington, Jacky Davis, Clare Gerada, Kailash Chand, and Emma Runswick expressed their support for Nagpaul, in a statement to *The BMJ*. "It is surprising and disappointing that some of the top leadership of the BMA claimed expenses for international travel by spouses," they said. "Ordinary members' subscriptions paid for those trips."

Another council member, Wendy Savage, praised her colleagues for bringing "these unsatisfactory governance matters" to light.

The BMA's board of directors, who are responsible for the management of the finances and general administration of the organisation, seemed to be unaware of the behaviour of the senior officers. J S Bamrah, who sat on the BMA's board for two years

(Continued on page 506)



**Chaand Nagpaul, chair of the BMA's ruling council, banned spousal travel expenses in January**

### LATEST ONLINE

- Bayer and Janssen pay \$775m to settle Xarelto misinformation claims
- Statistical significance should be abandoned, say scientists
- Spinal surgeon loses appeal in case of woman left disabled after heparin injection



# Gynaecologist is suspended for not resisting the “choice remark”

(Continued from page 505)

before stepping down in July 2018, said he had “absolutely no idea” about the claims and that members would be “rightly aghast” to learn of them. “I don’t know how often it happened, but once would be too many,” he said.

This is not the first time the BMA has been criticised for a lack of transparency over payments to senior officials. In 2004 it emerged that some consultants had been claiming large sums in compensation for private practice earnings lost while doing BMA work. And in 2015 the revelation that senior figures had secretly awarded themselves pay hikes of up to 137% provoked an internal row.

Nagpaul said that spousal expenses for senior officials other than the president did not appear to have fallen under any formal policy but that claims had been made according to “custom and practice.”

“A search of our archives suggests this practice may have been allowed in days gone by,” he said. “It certainly wasn’t current policy in 2017 when I became a chief officer. No one told me it was something I could do. Nor do I consider it an appropriate use of members’ money.”

Nagpaul has banned all spousal expense claims, including for the president. He added, “I intend, through the board, to have an independent assessment of our governance. “When I became chair of council I found, as in many organisations which have been around for over a century, that there were elements of ‘custom and practice’ as well as a lack of clarity with some processes and operating policies.

“I see this as an opportunity for the BMA to create a sense of renewal and put in place modern policies that are clear, and support our members.”

The BMA said, “We are aware that payments of expenses for some spouses have been made when accompanying past senior member officers to international events. On some occasions spouses have been specifically invited by the host medical association. The BMA board has already acted to end such payments.”

Melanie Newman, London

Cite this as: *BMJ* 2019;364:l1407

A gynaecologist who was found to have made insensitive remarks in front of colleagues—and in one case a patient—has been suspended for three months by a medical practitioners’ tribunal.

In an apparent effort to put a patient at ease before an abortion, the tribunal found, Keiron Timothy Moriarty (right) said, “Some women are not put on this earth to have babies. It’s a woman’s choice and just because Muslims try to bomb us back to the dark ages, it doesn’t change anything.”

The tribunal held the comment constituted serious professional misconduct, but was not motivated by racism.

Two other comments were ruled not to be misconduct, but constituted a pattern that taken together with Moriarty receiving GMC letters of advice about treating colleagues with respect in 2010 and 2013, justified the suspension.

## All female staff

Moriarty worked at a British Pregnancy Advisory Service unit in Milton Keynes, with an all female staff of nurses, midwives, and administrators. In December 2016, “Ms B” a lead midwife began work at the unit. “Dr Moriarty and Ms B did not get on,” said Angus Macpherson, the tribunal chair.

On learning that Ms B’s husband was away for three months, the tribunal heard that Moriarty joked, “So the rabbit will be getting a good workout.” Ms B replied, “You’ll be offering your services next.” He answered, “if you want.”

Tribunals should judge conduct by the standards in the unit, said Macpherson, and staff testified they frequently heard sexual banter when patients were absent. A healthcare assistant testified that Ms B had not

seemed upset at the time but became so a week later after a call from a manager that may have been triggered by Moriarty’s complaints about his operating lists.

The comments were found to be inappropriate but not serious misconduct. All of Moriarty’s behaviour stemmed from his being “not

able to resist the choice remark,” said Macpherson.

The tribunal found Moriarty lacked insight and risked repeating his misconduct, but in mitigation he was generally liked by colleagues and had no clinical shortcomings. Suspensions often end with a review hearing before the doctor resumes work, but this was not needed in this case, said Macpherson.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2019;364:l1390



## Poor surgeon teamwork is affecting care, finds college

Where problems occur in surgery, poor teamwork between surgeons is often a major factor, a review carried out by the Royal

College of Surgeons has found.

The college looked at 240 reviews of surgeons or surgical services carried out in the UK between 2008 and the end of 2017 after being invited by hospitals to investigate. It analysed 100 consecutive reviews, comprising 58 of a service, 25 of a surgeon, and 17 of clinical records.

Problems with team working were highlighted in 76 of 100 reviews, a report on the analysis said.

**Historically, surgeons didn’t work with a team, but those days have largely gone**

Stella Vig, RCS council member

A number of behaviours contributed, such as consultant surgeons not meeting regularly as a team and consultants working in isolation rather than together.

### Tension within teams

The analysis also found that creating new teams of consultant surgeons, through mergers or restructures of services, often caused tension between team members.

The report said that it was imperative that any difficulties in a surgical team were tackled at the earliest possible stage. “This will help ensure that consultants demonstrate appropriate behaviour and display high standards of teamwork, enabling the delivery of safe surgical care,” it said.

Commenting on the findings, Stella Vig, a general and vascular surgeon and college council member, said that most problems within surgical teams were managed locally so the college’s findings only represented a small of part of a much bigger problem.





# Patients “increasingly worried” amid Brexit uncertainty

A lack of information about Brexit's effects on drug supplies is creating a climate of fear among patients, despite repeated government reassurances that access will not be impeded, the Royal College of General Practitioners has said.

Helen Stokes-Lampard, college chair, said that reassurances from NHS England and the government that contingency plans were in place had not assuaged this fear. She added that the college was concerned that the lack of clear information may prompt some patients to take matters into their own hands and purchase unregulated products online.

“Our patients, particularly those with long term conditions, are

increasingly worried by the lack of information and their future care,” she said.

“The last thing we need is for people to panic, but without more detailed public information about what steps may need to be taken after Brexit, we run the risk of patients looking elsewhere for their drugs and perhaps turning to unregulated online companies—something that could have dangerous consequences for patient safety and the wider NHS.”

Stokes-Lampard said the college fully supported the government's guidance that GPs should not stockpile drugs, and said GPs were working to ensure that patients were ordering their drugs as normal to avoid creating or exacerbating wider shortages.

But she added: “We now need more detail about what patients and healthcare professionals need to do in order to minimise the impact of leaving the EU, both for the health of individuals and for the wider population.”

Russell Viner, chair of the Royal College of Paediatrics and Child Health, said it was understandable that patients and clinicians were “concerned and confused” by the latest political developments, but sought to reassure members in an email this week.

He wrote: “We have been clear that the dangers for children and young people's health, and for our members, lie in the uncertainty related to Brexit, not to particular scenarios. However, sadly, at



## We run the risk of patients looking elsewhere for their drugs

Helen Stokes-Lampard

the current time, uncertainty is in the ascendant.”

He added: “I have been reassured by preparations relating to drug supplies. We have seen that governments, the Medicines and Healthcare Products Regulatory Agency, and the NHS have been working hard behind the scenes and we believe drug supplies are largely secured, with stockpiling appearing to be the biggest risk.”

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l1397



MARK THOMAS/SPL

“A lot of disputes, poor behaviour, or poor team working are actually managed within trusts really well, so any fears about patient safety are put to bed early on,” Vig said.

“The invited review mechanism is the tip of the iceberg. It happens when internal mechanisms have not been able to resolve what are sometimes deeply rooted behaviours.”

While the college's report focused on surgeons, Vig said the findings were relevant

to all doctors. “Historically, surgeons didn't work with a team, but those days have largely gone. Surgeons have led the way with multidisciplinary team working,” she said.

The analysis also found that in 54 of 100 reviews there were concerns about the inappropriate behaviour of a surgeon or about a lack of respect between surgeons and within teams. The report said that surgeons in difficulty could become dismissive when concerns were raised about their behaviour,

## PROBLEMS with team working were highlighted

in 76 of 100 reviews, a report on the analysis said

and could become “difficult to manage, controlling, or arrogant in their approach.”

In 57 of the 100 reviews the college identified problems with multidisciplinary teamwork, including teams being unable to effectively manage disagreements about patient care and uncivil behaviour between group members.

The report sets out recommendations for improving the quality of surgical practice. These include acting on concerns at an early stage before they affect patient care and ensuring that surgeons have appropriate facilities and resources.

Vig said that these recommendations could be helpful. “As a clinical director I can take that list, transform it into a checklist, and ask my surgical colleagues if we can honestly say that we are doing all of these things,” she said.

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2019;364:l1371

# SEVEN DAYS IN

## Child poverty in Scotland is set to worsen despite targets set in 2017



GETTY IMAGES

Child poverty in Scotland is projected to hit a 20 year high in the next few years, despite ambitious Scottish government targets. The Resolution Foundation analysis warns that radical action will be needed if politicians are to meet their targets.

Its report *Wrong Direction* blames welfare policies introduced in 2015 by the UK government for the projected increase. These include a four year freeze on working age benefits and a two child limit on support, which will cut £12bn from welfare payments. The UK government then abandoned its statutory commitment to eradicate child poverty by 2020.

The Scottish parliament took a different approach, unanimously approving the Child Poverty (Scotland) Act in 2017. It's a commitment to reducing relative child poverty to below 18% by 2023-24. The latest figures, for 2016-17, show that 23% of children (230 000) across Scotland were living in relative poverty (living in a household with income below 60% of the median). This is significantly lower than the overall UK rate of 30%. The projection, based on economic forecasts and policy analysis, is that relative child poverty will rise to 29% in Scotland by 2023-24.

Bryan Christie, Edinburgh [Cite this as: BMJ 2019;364:l1370](#)

### Staffing

#### Leadership on wards can improve care, says NIHR

Investing in ward leaders could improve patient care and help to attract and retain nursing staff, said a National Institute for Health Research review of 22 nursing and staff related studies. Deciding on the number of nursing and other staff needed for individual wards was complex, it said, and people responsible for staffing numbers needed proper training, while wards needed good leadership to create environments that got the most out of staff.

### Assisted dying poll

#### RCP adopts neutral stance on assisted dying

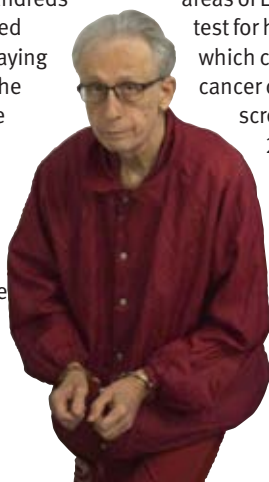
The Royal College of Physicians will remove its opposition to assisted dying and take up a neutral stance, after there was no supra-majority in a members' poll. Of the 6885 doctors who responded (20% of the RCP's members and fellows), 43% voted for the college to oppose a change to the law. This was similar to the 44% in a 2014 poll. A third (32%) wanted the college to support a change in the law, up from 25% in 2014, and a quarter (25%) thought

that it should be neutral, down from 31%. Andrew Goddard, RCP president, said, "Neutral means the RCP neither supports nor opposes a change in the law, and we won't be focusing on assisted dying in our work. Instead we will continue championing high quality palliative care services."

### US conviction

#### Paediatrician is sentenced to 79 years for child abuse

Johnnie Barto (below), 71, a Pennsylvania paediatrician, will spend the rest of his life in prison after being convicted for the abuse of 31 children. Barto had first faced three allegations of fondling child patients in 1998, and the state's Bureau of Professional and Occupational Affairs removed his licence, but hundreds of people expressed support for him, saying he was a pillar of the community. A nine member panel, mostly doctors, then voted 7-2 to restore his licence 19 years ago, ruling that the allegations were "incongruous to his reputation."



### Cervical screening

#### Capita is stripped of service contract

From June, NHS England will take back the running of the NHS cervical screening programme from Capita, said Simon Stevens, NHS England's chief executive, explaining that he had "not been satisfied" with how the private company ran the programme. Last year Capita failed to send as many as 48 500 women their screening invitations, reminders, and results because of a system error.

#### DIY kits for women who miss smear tests

Women who miss appointments for cervical smear tests will be sent self sampling screening kits as part of a pilot scheme in two areas of London. The kits will test for human papillomavirus, which causes 99% of cervical cancer cases. Uptake of cervical screening is currently at a 20 year low and, if self sampling improves this, it could be rolled out nationally. Self sampling is used in several countries including Australia, Denmark, and the Netherlands.

### Medicines

#### Three batches of losartan tablets are recalled

The Medicines and Healthcare Products Regulatory Agency recalled three batches of losartan tablets because of contamination with the nitrosamine N-nitroso-N-

methyamino-butyric acid (NMBA).

The recall is part of its continuing investigation into the potential nitrosamine contamination of "sartan" products. No evidence has shown that nitrosamine impurities can cause harm, and patients are being advised to continue taking the drug. The agency has previously recalled tablets containing valsartan and irbesartan.

### NHS performance

#### Emergency readmissions to hospital on the rise

The proportion of patients discharged from hospital and then readmitted as an emergency within 30 days rose from 12.5% in 2013-14 to 13.8% in 2017-18, figures from NHS Digital showed. Patients with cancer or obstetric conditions were excluded from the figures, which were published for the first time in five years as experimental data.



# MEDICINE

## Research news

### Sedentary behaviour costs NHS £700m a year

Spending long periods sitting or lounging around is linked to around 70 000 deaths a year in the UK. It also costs the NHS more than £700m a year treating type 2 diabetes, cardiovascular disease, and colon, endometrial, and lung cancers that result, said research in the *Journal of Epidemiology & Community Health*. The £700m estimate is conservative as sedentary behaviour is likely to be associated with other cancers and musculoskeletal and mental health disorders not included in the analysis, said the authors.

## Primary care

### Practices must take on more clinical support staff

The only way to meet primary care demand is to expand multidisciplinary teams, said a joint report from the Health Foundation, the King's Fund, and the Nuffield Trust. Anita Charlesworth, a Health Foundation director, said, "We have a gap today of just over 2500 full time equivalent GPs. Despite the commitment to increase the number by 5000 by 2020 what we will actually see—without action—is a fall in the number of GPs."

## Life expectancy

### Stalling figures grind to a halt in England

Provisional 2018 estimates of life expectancy for males and females at birth remain the same as in 2017 (79.6 years and 83.2 years respectively), showed Office for National Statistics figures. "After eight years of stalling life expectancy, ignorance can no longer be an excuse for inaction—urgent measures must be taken to reverse this worrying trend," said Veena Raleigh, of the King's Fund. Reasons included cold weather,

flu, slowing improvements in heart disease mortality, rising deaths from drug misuse, and widening inequalities, she said.

## Brexit

### BMA leader demands final say at London march

Chaand Nagpaul, BMA council chair, gave a rallying speech at the "Put it to the People" march (below) in London on 23 March. He compared the denial of a second public vote on the Brexit

deal to doctors denying patients the chance to change their mind about an operation. "Brexit is bad for health, bad for patients, and bad for the NHS," he said. "Just as doctors give patients the chance to think again, for the sake of our NHS let us, the people, have the final say."

## Zika

### Warnings ease as growing immunity reduces risk

WHO is to relax its Zika travel recommendations, days after the US Centers for Disease Control and Prevention eased warnings that pregnant women or those seeking to become pregnant should avoid 88 countries. The UK announced similar changes in February. The agencies now discourage travel only to areas with active outbreaks, currently only one (Rajasthan, India).

Cite this as: *BMJ* 2019;364:l1376



## SIXTY SECONDS ON... PEE, POO, AND SICK



### SOUNDS LIKE A BAD NIGHT WITH A POORLY TODDLER

Shudder. These evocative terms actually feature in a new A to Z of NHS Health Writing from NHS Digital, which details words and phrases that the health service commonly uses in its online content for patients.

### WHAT'S WITH THE SCATOLOGICAL TERMINOLOGY?

The NHS says it wants to use words that are easy to understand, unambiguous, and used in everyday conversation. Which means that "being sick" replaces "vomiting"—and "poo" trumps "stools" or "bowel movements," figuratively speaking.

### ISN'T THIS JUST DUMBING DOWN?

The NHS acknowledges that some people might not like this approach, but argues that it's important to use clear and direct language that's widely understood by people of all ages and literacy levels.

### HOW DID THEY DECIDE WHAT TO INCLUDE?

By testing a range of words on people with different levels of literacy. Everyone understood "pee" and "urine," so they got the nod ahead of "wee"—which can be confused with "we" or "wee" (meaning "tiny" in some dialects).

### HAVEN'T THERE BEEN OTHER JARGON BUSTING INITIATIVES?

There have. In 2018, for example, the Academy of Medical Royal Colleges launched the Please Write to Me initiative, which urged doctors to stop using complex medical phrases or Latin abbreviations in their clinical correspondence to patients.

### COGITATIO BONA. BUT WHAT'S THE END GAME?

Ultimately, the NHS believes that flushing out the jargon will improve the care of patients. As NHS Digital's Sara Wilcox explained in a blog post outlining the rationale for the changes, "If someone with poor literacy understands 'blood in your poo,' it might just save their life."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l1358



# Call for psychological support to reduce “appalling” number of GP suicides

**T**he BMA's General Practitioners Committee must lobby ministers for increased psychological support for GPs to reduce the “appalling” number of suicides among doctors, local medical committees have urged.

The annual UK LMC conference in Belfast passed a motion on 19 March in recognition of “the appalling statistics and circumstances of doctor suicides.” The conference instructed the GPC to raise the issue of GP suicide with “all major stakeholders” to seek a better understanding of any “preventable triggers and adverse drivers.”

The motion was proposed by Lucy Henshall (pictured) of Suffolk Local

Medical Committee, who received a standing ovation after delivering a moving speech in which she spoke about the suicide of her friend and colleague Richard Bennett in 2013.

## Systemic failure

Henshall spoke of a “systemic failure” by the NHS and wider society to look after sick GPs. She highlighted figures from the Office for National Statistics showing that 430 health professionals in England and Wales died by suicide from 2011 to 2015, including 81 doctors, and that female GPs

have four times the risk of suicide than the general population. She also noted figures showing that a third of GPs experience depression, burnout, or both.

“As GPs, we deserve more than signposting to mindfulness,” she said. “Resilience alone will not keep GPs safe and well. We deserve to be cared for ourselves, supported and encouraged in our daily work, valued and cared for when we are well, and, most of all, cared for if we become unwell. Because, conference, we are also human.”

She added, “We have a duty beyond this

**FROM 2011** to 2015 figures show that **430** health professionals in England and Wales died by suicide

## NHS should not “pick up the pieces” of private screening

Private screening providers should be mandated to provide follow-up appointments with patients to discuss abnormal results and should not offload responsibility to the NHS, LMCs have argued.

A conference motion argued that GPs should be empowered to invoice private screening providers directly for their time if, as NHS GPs, they provide follow-up appointments to patients who were scanned by a private service.

The motion also contained a call for health screening to not take place in the NHS without the approval of the UK National Screening Committee.

Ciaran Kelly of North and North East

Lincolnshire LMC, who proposed the motion, emphasised that screening tests must satisfy a strict set of criteria before they can be recommended for use in the NHS.

“Private companies don’t care about these strict criteria,” he argued. “They are in it for the money, pure and simple. Should they find something untoward, then the patient is immediately forwarded on to the NHS to pick up the pieces, including explaining tests that were not ordered by their GP and should never have been organised in the first place. They want to offload that responsibility as quickly as possible to us.”



**They are in it for money, pure and simple**

Ciaran Kelly, North and North East Lincolnshire

leaving the dishwasher for the already stretched primary care services.”

He added, “I send letters to hospital consultants all the time saying, ‘If you want this test doing, order it and follow it up.’ I don’t see why we should give private industry a free pass.”

## Approval

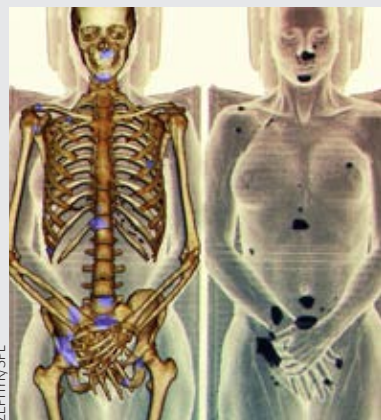
Ansar Hayat, of Wakefield LMC, spoke against the call for screening not to take place in the NHS without the approval of the National Screening Committee, arguing that some unapproved screening was already available on the NHS and could provide benefit. “We should let the patients do what they want to do,” he said.

Sam Creaving, of Avon LMC, urged the BMA’s GPC to work with public health agencies and guideline development groups to ensure that GPs were resourced and protected for the work they do. “We want to make sure that we can deliver a high quality standard of care in a way which we are involved with,” he said.

The motion was passed in full.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l1289



**As GPs, we deserve more than signposting to mindfulness**

Lucy Henshall, Suffolk LMC



SARAH TURTON/BMA

room to get the message out there.”

The motion also called for the GPC to lobby the government to “adequately resource proper psychological support systems for all GPs,” including those who are on parental or sickness leave or out of work, to prevent occupation related mental distress from developing.

Delegates also voted to call on the GPC to press for proper, NHS funded coaching

and supervision services to be made available to all GPs.

Sarah Westerbeek of Kent LMC was one of several GPs to speak in favour of the motion. “Make no mistake, this is a crisis,” she said. “An increased risk of suicide is an entirely unacceptable occupational hazard, and we must act now.”

Gareth Iacobucci, *The BMJ*

[Cite this as: BMJ 2019;364:l1286](#)

## “Locum GPs must have same death in service benefits as other doctors”

The BMA’s General Practitioners Committee must actively seek changes to the NHS pension scheme to make it fairer for all GPs, the LMC conference urged.

Delegates unanimously called for sessional GPs to have the same death in service benefits as the rest of the GP workforce.

### Ineligible

The NHS pension scheme provides a lump sum and pension benefits to a doctor’s dependants in the event of his or her death. However, some locum GPs are not eligible for this benefit.

Andrew Parkin, a locum GP from Kent LMC, said that despite many benefits to being a sessional GP, the death in service benefit rules were a major disadvantage. “I know that on Friday I am going to see 16 patients in the morning,

16 in the afternoon, and not have any extras or visits and get home to see my children,” said Parkin. “If the deluge of Med 3 [forms] and secondary care requests cause me to have an aneurysm at my desk on Friday I know that my wife will get my pension.

“However, if on my way home tonight I fall into the baggage reclaim area and get mangled she will get nothing, unless she wheels me in to work and props me up at the desk. I think this is a scandal and locums should have the same death in service benefits as all other doctors.”

David Bailey, GP and BMA Cymru Wales council chair, said that the BMA had made an appeal about the issue to the pensions ombudsman.

He added, “It’s totally immoral that locum doctors can, depending entirely on the time of their death,

either leave their families destitute or get pensions passed to their families.”

### Pension tax problems

Delegates also called on the GPC to seek pension changes. Proposing the motion, Ian Morris, of Devon LMC, said he had been told of GPs who have had to remortgage to pay unexpected pension tax bills. “We all know that pension problems are a major factor in GPs dropping their hours [and] retiring early,” he said.

Bailey warned that changes to the annual allowance—a threshold that restricts how much a doctor’s pension can grow each year before tax charges apply—were going to cause a “tsunami” in the number of GPs of all ages reducing their working hours.

Abi Rimmer, *The BMJ*

[Cite this as: BMJ 2019;364:l1331](#)

## Bullying: “Protect whistleblowers”

A motion passed by delegates deplored bullying and said that such abuses of power had no place in healthcare.

Proposing the motion, Iain Kennedy (right), a Scottish GP, talked about his experiences as a whistleblower. “There has been a toxic culture in NHS Highland for 10 years, possibly longer. A culture that promotes fear and intimidation,” he said.

He said that a fitness to practise body for managers was long overdue, “so that serial bullies are removed from the NHS... We also need a robust whistleblower support structure for primary care.”

Andrew Mercer, of Devon LMC, supported the motion, saying he had grave concerns about local NHS England representatives bullying general practices. “Despite having a GMS [general medical services] contract, local NHS representation appears to feel the need to be in the driving seat,” he said.

[Cite this as: BMJ 2019;364:l1348](#)

## Brexit: “Sort it out” and protect patients

The conference unanimously voted to call on the government to take immediate steps to mitigate the “devastating” effect that Brexit may have on healthcare, particularly in Northern Ireland.

Northern Ireland GP Frances O’Hagan (above) proposed the motion that highlighted the particularly serious problems facing Northern Irish GPs. She said the threat of a no deal Brexit had left huge questions over issues such as the mutual recognition of medical qualifications, the movement of healthcare workers across the Irish border, access to drugs, and access to cancer services.

“Ten per cent of our doctors are qualified in the EU, most of them in the Republic of Ireland. This is a disaster. So, I’m saying to our politicians, for God’s sake, you’ve had two years at it. Sort it out.”

[Cite this as: BMJ 2019;364:l1295](#)





# Why is joint working out of public sight?

NHS trusts' working arrangements with drug companies are meant to be open and transparent, but, as **Tom Moberly** reports, details of many deals are not available to patients or the public



**Arrangements are being designed first and foremost around the interests of pharmaceutical companies**

Robert Morley, Birmingham LMC

**N**HS organisations are entering into working partnerships with drug companies, but the details, and even existence, of many of these deals aren't being made available to the public, a *BMJ* investigation finds.

With government encouragement, the number of "joint working arrangements" is growing in England, and they brought more than £7.5m into the health service in 2016 and 2017. Examples include several projects to review the medications of people with ADHD and more than 20 focusing on patients with age-related macular degeneration. But many of the agreements ignore official guidance that urges openness and transparency.

*The BMJ*, working with a team of university researchers, used freedom of information requests to get details of these arrangements, but a fifth of trusts would not release details. In one example a contract allowed for a drug company to be informed of any FOI request relating to the joint working arrangement. In another, the monetary details of a trust's joint agreement with a drug company were not recorded in the trust's financial records.

Drug companies disclose the funding for these projects in their declarations of payments to health professionals and organisations and they often publish information on their websites. But patients, members

of the public, and healthcare workers seeking information from their local trust about projects in which it has been involved would, in many cases, not be able to access it.

*The BMJ's* findings have drawn concerns that joint working arrangements camouflage NHS underfunding, that such partnerships risk influencing doctors' clinical decisions, and that it is unethical not to open up these deals to public scrutiny.

The growth of these collaborations is expected to continue under the NHS Long Term Plan, which lays out plans to treble its contracts and collaborative research with the industry over the next decade. The Disclosure UK database of payments from drug companies to UK health professionals and organisations shows that 51 of the 194 acute care NHS trusts in England (26%) were involved in joint working in 2016 and 2017. Companies spent £3m in 2016 and £4.7m in 2017 on joint working arrangements.

Over half of the money spent by drug companies on joint working in the UK went to acute care trusts in England, with some trusts receiving several payments. Funding also went to primary care organisations across the UK and to acute care trusts in Northern Ireland, Scotland, and Wales. From 2016 to 2017 the number of payments from drug companies to acute care trusts in England under joint working arrangements rose by 52%, from 60 payments worth a total of £2.2m in 2016 to 91 worth £2.3m in 2017.

The industry says that joint working projects can accelerate the spread of new treatments. "Joint working looks to pool resources and expertise behind an NHS priority to deliver improvements faster than if we all worked in silos," says Elaine Towell, head of media at the Association of the British Pharmaceutical Industry.

Buckinghamshire Healthcare NHS Trust says it has seen considerable

## The investigation

*The BMJ* worked with researchers from the University of Bath and Lund University, Sweden to see how many trusts were involved in joint working arrangements in 2016 and 2017 and what joint working policies they had. The team sent FOI requests to all 194 acute care NHS trusts in England. All the requests were acknowledged, and 173 trusts (89%) provided responses. The researchers compared this information with companies' declarations in the Disclosure UK database and in details listed on companies' websites.

benefits from such an approach. "The trust partnered with a pharmaceutical supplier in 2016 to create an eye facility at one of its hospitals to increase patient access," it said. "The benefits from a trust and patient point of view have been significant."

This project, a collaboration with Novartis, involved three new clinic rooms, two scanning rooms, one vision bay, and one injection room for patients with wet age-related macular degeneration. One aim of the project was to enable 90% of patients to receive treatment for wet AMD within one week of diagnosis.

## NHS underfunding concealed

But Cathy Augustine, who sits on the national steering group of Keep Our NHS Public, argues that allowing the industry to provide services in this way helps to mask the degree of government under-resourcing. "Services should be fully funded by the NHS," she says. "This approach not only opens the door wider to private interference and privatisation of our national health service, but it also draws a veil over the underfunding that is in place—it camouflages the underfunding."

*The BMJ's* investigation revealed a lack of transparency in joint working arrangements. The guidance of the



## WHAT ARE JOINT WORKING ARRANGEMENTS?

These initiatives, involving shared investment by the NHS and drug manufacturers, are designed to benefit patients, the NHS, and the companies. Proposed in the 2006 white paper *Our Health, Our Care, Our Say*, they were devised as a way for the industry to collaborate with the NHS. In 2008 the NHS and Department of Health for England published guidance on how the arrangements should work. And two years later—with the Association of the British Pharmaceutical Industry—they published a toolkit to support their development.





NHS and Department of Health is clear that joint working agreements must be conducted in an “open and transparent” manner. “There should be sufficient transparency about NHS activities to promote confidence between the organisation and its staff, patients, and the public,” it says. Trusts are also expected to record and monitor all funding agreements related to the joint working projects.

Despite this guidance, 35 acute care trusts (18% of England’s total) refused to release information in response to *The BMJ*’s request. Twelve (6%) said providing the information would prejudice their commercial interests, eight (4%) said the time it would take to find the information would breach the limit for FOI requests, and two (1%) said the information had been provided in confidence so could not be released. A further 13 (7%) said they did not keep a central record of such arrangements. Other trusts claimed not to know about joint working arrangements (see box, right).

One trust said that disclosing information to *The BMJ* “would be detrimental to its commercial interest” and could “prejudice the position of the trust in maintaining its competitiveness as a public authority.” Another said that details of the money the NHS had contributed

### The industry says joint working projects can accelerate the spread of new treatments

to a particular joint working arrangement could not be released. “The trust has made a proportionate contribution which, in the interests of confidentiality, we are not able to describe in more detail,” it said.

*The BMJ* asked all trusts involved in joint working arrangements to provide details of the documents underpinning the projects, but only one provided such a document (see box, overleaf).

Robert Morley, executive secretary of Birmingham LMC, says the NHS organisations have clear obligations to be open and transparent about the details of any joint working initiatives. “The lack of transparency over these arrangements is truly shocking,” he says. “For them to use the lame excuse of commercial confidentiality to disguise what’s going on would appear to constitute blatant neglect of their obligations.”

### Register of joint working

Alongside the need for transparency, the guidance is specific about the need for NHS organisations to have a central register of joint working projects.

Yet 13 trusts said that they could not provide the information requested by *The BMJ* because they did not keep a central record of such arrangements.

### “This is not a term used by the trust”

Some NHS trusts said they did not keep a register of joint working arrangements, while others said that they “did not recognise” or were “not familiar” with the term. Different terms were used by 80 trusts, either in addition to “joint working arrangements” or instead. One trust, when asked whether it was involved in joint working arrangements, said “this is not a term used by the trust.” When sent details of a joint working project involving the trust, along with the NHS’s definition of joint working, a spokeswoman acknowledged that the project did fit the definition. But she went on to say, “The trust does not categorise contracts as ‘joint working arrangements’ as we do not find it helpful to do so.”

One trust said that it could not provide the relevant details because the information was held by one person who no longer worked at the trust. Others said information was held by individuals in different departments, rather than being in a central register.

Of these 13 trusts, eight were listed in drug companies’ declarations of payments for joint working.

Even when trusts did provide details of joint working, the information they provided was often inaccurate or contradicted by

## JOINT WORKING IN EAST LONDON

An agreement between Barking, Havering and Redbridge University Hospitals NHS Trust and Novartis is for a nurse led project to develop the provision for patients with myeloproliferative neoplasms. Novartis jointly funds a clinical nurse specialist service to relieve pressure on outpatient haematology clinics at Queen's Hospital in Romford. The agreement says, "These clinics are frequently overbooked with long 'in clinic' waiting times leaving less time for treatment reviews, exploring potential underlying problems and complex cases." The service also works with patients with long term illness being treated through a telephone and repeat prescription service and who may be in need of a "treatment review." Under the deal the trust agreed that in the event of an FOI request it would "give proper consideration to any representation made" by Novartis before deciding how to respond. And Novartis can raise objections against any other organisations the NHS opts to work with in the project.

other sources. In all, 39 trusts said they did not have any joint working arrangements even though *The BMJ*'s investigation found them listed as being involved in joint working initiatives on either drug company websites or in the Disclosure UK database. Information from the database indicates that these projects accounted for £2.6m of the £7.7m in payments from drug firms for joint working in 2016 and 2017.

Royal United Hospitals Bath NHS Foundation Trust says none of the monetary agreements with the drug company were recorded in its finance systems. It adds, "The issue from the finance point of view is that we don't necessarily know about these as we

aren't receiving any financial benefit from them directly in terms of being paid or getting discounts."

### Benefits to patients

John Puntis, a consultant paediatrician and secretary of Keep Our NHS Public, says that joint working information should be being made available to patients and the public. "There's no reason for it not to be entirely transparent if it is supposed to be a win-win situation on both sides, and the NHS and patients benefit, and there are no strings attached in the sense that prescribing practice or clinical practice isn't being distorted by the company," he says.

"There's no question there may be some positives. But how do you judge that unless you have access to the information?"

In terms of benefits, joint working arrangements are designed to generate positive outcomes for patients, the NHS, and the companies involved. In many projects the benefits for companies are explicitly described as being "more use of medicines," "improved access to innovative medicines," or an "increase in access to innovative medicines."

### Whose interests?

Using information on drug company websites, *The BMJ* examined the focus and approach of 93 projects running in 2016 and 2017. Of these, 73 involved reviewing patients' treatment and prescribing additional or alternative drug treatment, if appropriate.

These projects typically involved either developing patient registries or setting up treatment review clinics. In both cases the aim was to identify patients who might benefit from "relevant and most appropriate treatments" or "to improve access to innovative medicines and treatment."

Many of the projects specifically referred to increasing the use of products marketed by the funding company. For instance, a series of projects in which Bayer is a partner would "improve NICE-approved medicines optimisation of injectable therapies, of which Bayer's aflibercept is one." Another project is "intended to create more opportunities for the appropriate use of ophthalmology licensed medicines, including Novartis medicines."

In terms of determining the patient groups that should benefit from joint working arrangements, the health department, NHS, and ABPI suggest that ideas should come from NHS organisations. The toolkit on joint working developed by the health department, NHS, and ABPI describes the way in which NHS organisations should identify opportunities for joint working and put proposals to companies. The NHS and health department guidance on joint working is also clear about the need for joint development of projects across the NHS and industry.

Some trusts say that they have approached companies to seek their involvement in joint working

## PATIENTS' PERSPECTIVES



**We can see no reason for the NHS to be secretive**

Cathy Yelf, Macular Society

Age-related macular degeneration or related conditions were the focus of 22 joint working projects in 2016 and 2017. Cathy Yelf, chief executive of the Macular Society, says that details of such arrangements should be publicly available.

"We can see no reason for the NHS to be secretive about this work," she says. "We understand from anecdotal examples that these partnerships have brought benefits to patients

in at least some areas. But no such partnership should influence doctors' clinical decisions."

Three joint projects in 2016 and 2017 involved reviewing the medication of people with ADHD. Sheila Keeling, chief executive of support charity Addup, says she didn't think this was a good use of NHS money: "I'm not averse to the drug companies putting money into this. What I don't like is the idea of the NHS putting money into this,



**They need to be looking at what is not working**

Sheila Keeling, Addup

because they don't have any money."

Keeling argues that NHS investment would be better spent elsewhere. "If they want to provide a better service for children, they need to look back at child and adolescent mental health services," she says. "They need to be looking at what is not working."

Six projects carried out in 2016 and 2017 focused on tuberous sclerosis, a rare genetic illness affecting one in 20 000 people.

Paula Davis, whose 19 year old son William has the condition, says it is important that information about projects such as these that have used NHS funding should be made available.

"It would be better if the community knew about them, particularly if it is NHS money," she says. "Transparency is very important. If it's public money it should be transparent. What would be the reason it isn't?"

arrangements. Yet, in some cases companies have approached trusts or are involved in similar or identical projects with different NHS trusts. Of the projects *The BMJ* examined in detail a quarter (25 of 93) were the same as at least one other project in a different trust in 2016-17. A Roche spokesman said that the company had used both approaches. "In some cases, we identify an opportunity to work with a trust, and on other occasions the trusts approach us," he says.

"Any decision for our involvement is based on identifying which project could have the greatest impact, being in an area where Roche has a high level of expertise."

Birmingham LMC's Morley says that the NHS should be taking the lead on determining the focus of projects to which it is committing investment. "NHS trusts should be prioritising the needs of their patients," he says. "Yet it appears that these joint working arrangements are being designed first and foremost around the interests of pharmaceutical companies."

"The extent to which trusts appear to be increasingly willing to be led by the nose by drug companies to work on projects that will boost their profits rather than benefit their patients is of massive concern."

Puntis argues that the lack of contract negotiating expertise in NHS organisations has meant that the health service is often at a disadvantage. "The NHS tends to get run rings around by the private sector when it comes to contracts and arrangements," he says. "I think trusts probably invite pharmaceutical companies in without thinking about the broader consequences of what it might involve."

In addition, the objectives of private drug companies differ fundamentally from those of NHS organisations, Puntis says. "It is not altruism; at the end of the day it's profit," he says. "My concern would always be, 'What's in it for the private sector?' They never do these things purely for the benefit of the NHS and the benefit of patients. They're often buying goodwill as well."

"Doctors say, 'Well, we're not influenced by the drug companies,' but clearly they are, because otherwise the industry wouldn't be pouring all the money into it."

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## MEDICAL RESPONSE TO TERRORISM

# From the Christchurch mosque shootings to London Bridge

Practices that develop in the heat of extreme situations have applications in day-to-day healthcare, finds **Rebecca Coombes**



RICHARD H SMITH

"It was around 10 pm," says Mike Christian, "and we had just dropped off a patient at the Royal London Hospital when the call came to respond to a road traffic collision—a car versus pedestrian—and we were dispatched to Tooley Street at London Bridge, less than 10 minutes away."

Christian is a doctor with the Helicopter Emergency Medical Service (HEMS), which responds to serious trauma emergencies in and around London. On 3 June 2017 he was a first responder to the London Bridge terror attack.

### Major incidents

Aside from the day job Christian works with the NHS and the police to learn lessons from major incidents and improve future responses to crises. At the Risky Business conference this June (see overleaf for details) he will share insights into how the practices

that develop in the heat of extreme situations can be applied to everyday healthcare.

He spoke to *The BMJ* on the day of the recent mosque shootings in Christchurch, New Zealand, commenting, "We know that these crisis situations will keep coming, as we unfortunately see today. From experiences at London Bridge, the Bataclan in Paris, and others, we know that some of the challenges are actually quite predictable, and it is important for us to plan in advance and come up with ways to learn to deal with them."

A Canadian living in London, Christian is a critical care physician and former military doctor who was in his first month with HEMS at the time of the London Bridge attack. During a 30 year career he has cared for patients with severe acute respiratory syndrome in Toronto, and he joined a national team investigating the outbreak; he was part of the medical response in Haiti after the 2010 earthquake; and he





Emergency services attend to casualties of the London Bridge attack on 3 June 2017

DANIEL SORABJI/AP/GETTY IMAGES

has advised governments and hospitals on critical care in austere environments and emergency preparedness.

“So, when London Bridge happened it’s maybe fortuitous that I was working that day along with a paramedic,” he says. “She just happened to be one of the resilience leads for London Ambulance. We both had a fair amount of background knowledge and experience that night.”

En route to Tooley Street—by car because of the dangers of landing a helicopter at night—the HEMS team were told of multiple patients at the crash site. Within minutes another update gave a report of possible stabbings. “That’s when the penny dropped that this might be something more,” says Christian.

Three terrorists travelling south across London Bridge in a van had deliberately driven into pedestrians before crashing on Borough High Street. Armed with knives, they left the van and headed for Borough Market, entering pubs and restaurants, killing and maiming people as they went. Police shot the attackers dead within nine minutes. Eight people were killed and 48 injured.

Hearing the police shots over the radio, the HEMS team were forced to turn back to the north side of the river. “We headed to the north side of London Bridge to set up a casualty clearing area: crowds of people were being directed from Borough Market,” says Christian. “Usually, where it’s one patient, the first thing we start doing is treating people. But in this situation the most important thing, particularly in

a leadership role, is to start coordinating other people into action, because you need a larger response and you have to get that set up in order to help most patients.”

### Therapeutic vacuum

Since the attack, an emerging issue for the police and the NHS has been how to stop doctors and other responders from being shut out of crisis areas during a fast moving security operation. The risk in such tense situations is that a “therapeutic vacuum” arises, says Christian.

“This is where a lot of resources coming into the scene get shut down because it’s unclear exactly which areas are safe and which are not,” he explains. “Once it’s a declared terrorist incident you get a higher level of control: this also came up with the Manchester bombing [in May 2017]. But it can create difficulty in getting additional resources to the scene.

“At London Bridge we were trying to pull resources in, but in the meantime it was a case of mobilising people who just happened to be there and were caught up in the incident—particularly off-duty junior doctors, nurses, and police officers. We put them to work and started to form ‘instant teams.’”

He explains, “It’s always amazing to me, how calm people can be. Lots of civilians were going above and beyond, carrying victims across the bridge, and doing first aid—some literally taking their shirts off their back for bandages. People were scared, but they were actually very effective, and they took instructions very well.”

**Mike Christian: “As a leader, the most important thing is to start coordinating other people into action”**

The concept of instant teams, he says, is one that translates into everyday healthcare: “A crisis occurs, such as a cardiac arrest on the ward, and suddenly a somewhat random group of people who just happen to be on call come together. They may have never met each other before, and they have to work together in effective ways to provide lifesaving care.”

As well as therapeutic vacuums there is a threat of multiple attacks and the confusion this creates. The London Bridge attack occurred on an average weekend night in London—always very busy for the team, typically with dozens of calls about stabbings and other assaults coming into the operations centre. “The rest of London just doesn’t stop happening,” says Christian. “During the attack, when other calls are coming in, you wonder: is this just another regular incident, or is this another terrorist attack starting somewhere else?”

“This happened at the Bataclan in Paris, and it’s one of the things that we’re very attuned to. You saw it with Christchurch, too—you need to expect the potential for multiple locations and multiple attacks.”

### Limited and changing information

The challenge of making decisions when you have limited and changing information is not so different from other types of alerts in a hospital, such as a sick patient suddenly having a medical emergency.

“Some of these scenarios aren’t unpredictable, so these things don’t need to be unexpected and chaotic,” says Christian. “We know there’ll be communication challenges, and we know that information will rarely be as clear as it could be, but there’s still an imperative to act, to deliver care and make a difference for these patients.”

He left London Bridge around 2 am on the night of the attack. There was an immediate debrief the next morning but then a call to respond to another unfortunate stabbing. Christian’s military background and the full support of the air ambulance service have helped him to build up a psychological resilience.

“The jobs keep coming in, and we have to keep responding,” he says. “The attack reinforced a lot of the work I was doing and has made me more passionate about the need to continue to improve our response.”

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Mike Christian will be speaking at the Risky Business conference in June with fellow HEMS doctor, Claire Parkes. To book and to see the rest of the programme go to <https://www.riskybusiness.events/risky-london-2019-conference>

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# Birthday thoughts: NICE at 20

Cost effectiveness body should stick to what it's good at

All healthcare systems ration care. The creation of the NHS in 1948 as a universal tax funded system, largely free at the point of use, was an explicit rejection of rationing based on price and the ability to pay. But the need to decide between competing demands on a limited budget remained.

For half a century, the NHS grappled with this rationing dilemma through a combination of, as Rudolf Klein has characterised it, delay, dilution, deterrence, denial, and deflection.<sup>1</sup> This solved the problem after a fashion, but inconsistently and opaquely. The creation in 1999 of what is now the National Institute for Health and Care Excellence (NICE) was an attempt to tackle that through a systematic, evidence based, and economic approach.<sup>2</sup>

The essential question it was set up to answer is whether new technologies are not just clinically effective—in the case of medicines, they have to be to get a licence—but cost effective.

## Survivor

NICE has bucked the trend by surviving two decades without the frequent reorganisation and staff changes, or indeed abolition, that other national healthcare bodies have experienced. “Surviving” may seem a rather weak achievement. But it says something important about not only the organisation and its staff but the importance of its role, which goes to the heart of unavoidable prioritising dilemmas in a national health service.

The reasons for setting up NICE as a separate entity from the body that licenses medicines still apply. Successive secretaries of state (with one exception) have recognised that they are not best placed to make decisions about cost effectiveness and that real political dangers arise should they seek to do so. Initial unease in the pharmaceutical industry—and outright opposition from some quarters<sup>2</sup>—has

mellowed into a somewhat reluctant acceptance, and an acknowledgment that a clear and fairly transparent decision making process is better than the alternatives.

The history of NICE has nonetheless been marked by controversy. For example, the extent to which there is a definitive cost per QALY (quality adjusted life year) threshold, whether this is set at the right level,<sup>3</sup> the speed of the decision process, and whether it says yes too often or not often enough. But politicians have in the main resisted the temptation to intervene. When they did, through the creation of the Cancer Drugs Fund in 2011, the fund's massive overspend and failure to meet its objectives<sup>4</sup> served to demonstrate why NICE was needed in the first place.

Although there are valid concerns that NICE decisions can distort the allocation of resources away from more cost effective treatments that have not been appraised, it has largely silenced the vociferous debate about “postcode prescribing” (unjustifiable geographical variation in the provision of treatments). But its effect on the speed of adoption of new technologies seems to have been less than hoped for. This is particularly true for non-pharmaceutical innovations where, unlike with drugs, commissioners are not required to fund NICE recommendations. Claims are continuing that the NHS is slow to adopt, although it is not clear how far NICE can be held responsible for the complex factors at play.<sup>5</sup>

Its less headline grabbing work—the development of clinical guidelines—has dealt with the confusing proliferation that existed previously. The guidelines have undoubtedly improved the quality of care, although again it is not clear—partly because it



**The institute has inspired the work of similar agencies across the world**

is extremely hard to measure—how far they are truly embedded.

## International admirers

Despite these cavils NICE must be judged a success, and a big one. The social and ethical values it has adopted, its processes, the involvement of the public in establishing its underpinning principles, and the formidable network of researchers and advisers it has created are widely admired internationally. It has inspired the work of similar agencies across the world. Its materials are frequently downloaded, translated, and adopted—the provision of these as a publicly available

resource is an important contribution to the wider global health community.

It faces, of course, continuing challenges. Some are of its own making; others are of the kind that face health technology assessment globally, such as how far assessment processes work well, not just in the case of rare and orphan drugs but for new, more personalised cell and gene therapies, which are eye wateringly expensive and can be difficult to evaluate.

The former challenges include NICE's edging—via the so called budget impact test<sup>6</sup>—towards making decisions not just about whether a treatment is cost effective but how fast it should be rolled out if NHS England is unable to negotiate a price that falls within the cost effectiveness threshold.

To date, the budget impact test has not had to be applied to a medicine. But NICE was set up merely to judge cost effectiveness, not to rule how quickly the NHS could afford to adopt technologies. This sullies its original purity in a way that could do lasting damage to its standing.

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CIGARS.





## THE BIG PICTURE

# Every breath you take...

“Breathing is so much more than simply biology. From babies’ first cries to our final dying gasps, breath is our constant companion on the journey through life.”

So says the Royal College of Physicians in its new exhibition—Catch your Breath—which includes this 1827 coloured etching by Henry Heath, *People Causing a Nuisance by Smoking in the Street*.

Drawing on art, philosophy, anthropology, medicine, history, music, and literature, the exhibition highlights the unique role of respiration in human life and culture. It also showcases research from the universities of Durham and Bristol’s Life of Breath project.

The displays illustrate that air pollution, disease, and tobacco have long had an effect on people’s health, with artefacts showing the medical response to breathlessness through the ages. Today a fifth of people in the UK have asthma, chronic obstructive pulmonary disease, or other respiratory diseases, and respiratory illness is the third biggest cause of death.

Catch your Breath is at the Royal College of Physicians, 11 St Andrews Place, London NW1, from 2 April

Alison Shepherd, *The BMJ*

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# Healthcare for people experiencing homelessness

A public health crisis caused by political choices

**T**he recent BMA report *Streets of Shame* highlights the growing crisis in healthcare provision for homeless people and indicates that the UK's rise in homelessness is now a public health disaster.<sup>1</sup>

According to the report, the average age of death among homeless people is 47 for a man and 43 for a woman; 597 people died while homeless in 2017, the highest number on record. Attendance at emergency departments by people experiencing homelessness trebled from 2011 to 2018.<sup>1</sup> The same period saw a steep rise in admissions: from 3378 to 9282.<sup>1</sup>

The charity Crisis estimates that 24 000 people are sleeping rough in the UK, substantially more than the official figure of 4751.<sup>2</sup> It also estimated that 82 310 households were in temporary accommodation on 30 June 2018, an increase of 71% since the low of 48 010 in 2010. This included 130 000 children.<sup>2</sup>

## Poverty and deprivation

Homeless people present to NHS services with histories of poverty and deprivation, childhood neglect and abuse,<sup>3</sup> educational exclusion, and contact with the criminal justice system.<sup>3,4</sup>

Alongside childhoods dominated by adverse events, people experiencing homelessness are also highly likely to have other physical or psychological conditions, including undiagnosed acquired brain injury, autism, or attention deficit/hyperactivity disorder; poor oral health; chronic back pain; obstructive pulmonary diseases; and cognitive deficits arising from poor nutrition and alcohol use.<sup>5</sup>

Homeless people experience some of the highest rates of bloodborne virus infections and tuberculosis. Rates of suicide and death from violence are extremely high.<sup>5</sup>



**The crisis has arisen from a perfect storm of rent rises, cuts to welfare and support services, and the lack of social housing**

To this list, we can add the serious psychological problems that so often result from negative early years' experiences, along with problematic substance misuse.

## Healthcare response

So what needs to happen? Homeless people need healthcare professionals to support them in trusting, sustained relationships, and in developing care plans that prioritise their most pressing concerns, delivered by strong multidisciplinary teams. A wide variety of health professionals should be involved, including occupational therapists, physiotherapists, psychologists, dentists, podiatrists, and optometrists.

The Pathway model for homeless healthcare ([www.pathway.org.uk](http://www.pathway.org.uk)) is becoming more established in the UK. Rooted in primary care, teams with expertise in homelessness reach into hospitals and, where possible, recruit trained former homeless people as "experts by experience." Initiatives such as London's mobile Find and Treat service are targeting tuberculosis and hepatitis C in excluded and hidden populations. Excellent results are being achieved by fully integrated services working in primary and secondary care and on the streets.<sup>7</sup>

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The next step is to join up fragmentary good practice and roll out the service models known to be effective. Every major city needs an "inclusion health" clinical network. Services need permission and support to cross administrative boundaries and join up around their patients. Joint planning and delivery are needed with local authorities, criminal justice agencies, and the voluntary and community sectors.

The Homelessness Reduction Act 2017 places a duty on health services to refer homeless people to local housing authorities. This duty is not widely understood or implemented.<sup>9</sup>

## Policy failures

This crisis of homelessness has arisen from a perfect storm of rent rises, cuts to welfare and support services, and the lack of social housing.<sup>10</sup>

There have been failures in UK housing policy over many decades. The UK has 27.2 million households<sup>12</sup> and roughly 28 million dwellings.<sup>13-16</sup> This tight relation between availability and demand creates scarcity, regional disparities, and upward pressure on rents. For 40 years there has been no political will to build truly affordable social housing. Benefit cuts, sanctions, and obstructive processes combine to deny people the basic means to survive. Destitution is the reality for many.<sup>17</sup>

The health harms that we see in people made homeless are driven by social and economic inequality. The health service is picking up the pieces, and by doing that better we can save some lives and mitigate some of the damage. But in the long term we need radical change in housing, education, criminal justice, welfare, and economic policy.

Homelessness is a serious healthcare problem, but it is the consequence of political choices.

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