LETTERS

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BIRTHPLACE AND OUTCOMES

Midwifery ratios might explain some differences in outcomes

On the basis of the study by the Birthplace in England Collaborative Group,[1] the Royal College of Obstetricians and Gynaecologists advocates advising first time mothers of the benefits of delivering in obstetric units or alongside midwifery units. Low risk multiparous women can deliver in any of the four locations.

However, research is needed to explain the high intervention rate in obstetric units even in this low risk pregnancy group. Possible confounders are epidural analgesia uptake rates, differing protocols for managing progress in labour and monitoring the baby, differing experience of healthcare professionals, and the opportunity for consultant involvement during intrapartum care.

Home birth has a midwifery ratio of at least 1:1, which most hospital units cannot achieve. Does the overall workload of a unit have an impact on maternal intervention? Robust information systems and regular audit of data are essential for such analysis. This 1:1 care might explain the differences seen rather than place of birth, and improving midwifery numbers in obstetric units might reduce intervention rates more effectively than moving delivery site.

More information is needed on the causes of adverse perinatal outcomes for the baby. Why were 20 of the 32 deaths in the home or freestanding midwifery units? Analysis by parity and birth setting with appropriate adjustments for Apgar score <4, neonatal seizure rate, and encephalopathy is needed.

Finally, further work on "risk stratification" is needed. Why did one in five women in the obstetric unit group have complications at the onset of birth compared with only one in 20 of the other low risk women?

This study should not be used to declare what is bad, but what needs to be done to make it better.

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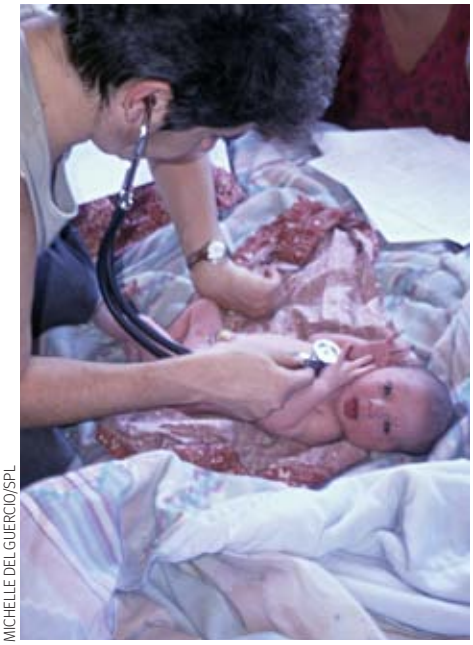
Competing interests: None declared.

1 Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011;343:d7400. (24 November.)

Cite this as: *BMJ* 2012;344:e891



MICHELLE DEL GUERCIO/SPL

Should we fund home birth for nulliparous women?

From comparison of home birth with hospital birth in the Birthplace in England national prospective cohort study,[1] an additional 14 caesarean and 18 instrumental deliveries will prevent one baby dying or being severely damaged. This is a remarkably small price to pay to prevent devastating outcomes for parents and high financial costs for society.

Healthcare purchasers should now question whether they should be funding home birth for nulliparous women. Purchasers have a duty to use public funds in a cost effective manner. Outcomes of home birth are poor, and the costs of this failure are very high.

Budgets for home birth should be diverted to birth centres. Alternatively, the supply of midwives in obstetric units could be increased; thus more women, including those at higher risk would be better supported while giving birth.

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Competing interests: None declared.

1 Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011;343:d7400. (24 November.)

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We need more data before reconfiguring services

For years, government policy has promoted home birth as a safe option. Now, for first time mothers, there are question marks. The Birthplace study, however, reports that freestanding midwifery units are safe.[1] Are they really?

For low risk nulliparous women without complications at the start of labour the risk of one of the serious "primary outcomes" is 22 cases out of 4785 in a free standing midwifery unit and 28 cases out of 8018 in an obstetric unit. And the risk of stillbirth for low risk nulliparous women is 0.4 per 1000 in a freestanding midwifery unit and 0.2 per 1000 in an obstetric unit.[2]

This is before adjustment for the increased risk profile of women choosing obstetric unit care and an acknowledgment that some data may have been lost as a result of transfer.

These figures do not reach statistical significance, but perhaps we should pause for thought, dig a bit deeper, and ask a few more questions before reconfiguring the entire country's maternity services.

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Competing interests: None declared.

1 Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011;343:d7400. (24 November.)
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Cite this as: *BMJ* 2012;344:e893

WHAT EVIDENCE FOR TELEHEALTH?

Telemedicine doctors abroad don't have to register with GMC

It may surprise and shock many patients, doctors, and the public that: "Doctors located outside the UK who practise remotely on UK patients are not currently subject to the same standards of and requirements for regulation as doctors located within the UK, and the patients may not have the same rights to redress."[1 2]

Doctors located outside the UK who practise teleconsultation, telemonitoring, teleradiology, telepathology, or teleprescribing on UK patients are not required by law to be registered or hold a licence to practice with the General Medical Council (GMC).

The risks to patients of this two tier system of medical regulation have been publicised for many years.[3] Instead of introducing legislation to protect patients whose healthcare is delivered by telepractitioners abroad, the Health and Social Care Bill, with its any qualified provider clauses, if passed, would increase the risks for patients in England.[4]

Legislation to empower and require the GMC to regulate all doctors who care for British patients, wherever the doctor is located and whether practising by telemedicine or face to face, should be introduced and passed urgently.

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Competing interests: None declared.

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Cite this as: *BMJ* 2012;344:e873

Daily contact with a nurse may be key intervention

My practice took part in the trials of telehealth and telecare mentioned by McCartney,[1] and I too saw no hard evidence, just anecdotal evidence that weighing was useful.

However, the direct daily contact with a nurse that goes with the programme may be more important. This was not trialled separately from the telehealth part of the trial, as far as I know.

In this new world of locality driven commissioning it is interesting that central NHS policy is to drive telehealth forward even if it's not wanted at a local level.

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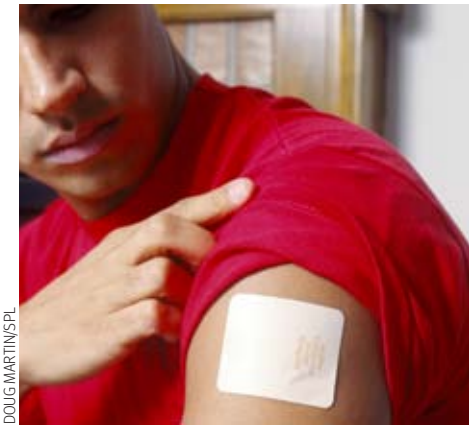
Competing interests: NJS's primary care trust/consortium may have to buy this service even if there is no evidence for it.

1 McCartney M. Show us the evidence for telehealth. *BMJ* 2012;344:e469. (18 January.)

Cite this as: *BMJ* 2012;344:e875



DOUG MARTIN/SPL

NICOTINE REPLACEMENT

Is nicotine replacement therapy worse than nothing?

A recent population level study, although small, found that the odds of smoking relapse in the first six months were 3.53 higher in heavily dependent quitters using nicotine replacement therapy (NRT) than in those not using NRT.[1] This is why Kamerow's reliance on the current favoured explanation for the failure of NRT, the selection bias theory, is misplaced.[2]

Nearly all population level studies since 2000 have found NRT no more effective than quitting without it. An unpublished 2006 National Cancer Institute analysis of 8200 quitters found slightly lower rates of quitting at nine months in NRT users than in non-users.[3]

A 2006 Australian study of family practice patients found that 88% of 2207 former smokers quit on their own, roughly double the rate of those taking NRT or bupropion.[4]

Training for UK NHS stop smoking facilitators all but forces "medication" on quitters, with a 93% programme use rate during 2011. Yet, annual four week rates consistently find that those who quit on their own do as well or better than those on NRT, and NRT users still have four weeks of treatment before attempting to adjust to natural dopamine pathway stimulation.[5]

NHS training lacks any mention of how real world quitters succeed, how counselling or support can substantially enhance quitting rates, or why the NHS declares success before treatment ends.

If NRT is less effective long term than quitting without it, are quitters paying with their lives?

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Competing interests: JRP is a pro bono director of a cold turkey nicotine cessation website.

1 Alpert HR, Connolly GN, Biener L. A prospective cohort study challenging the effectiveness of population-based medical intervention for smoking cessation. *Tob Control* 2012; published online 10 January.
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Cite this as: *BMJ* 2012;344:e886

MOBILE PHONES: UNHELPFUL APPS

Might wipe clean covers for mobile phones reduce risk of spread of pathogens?

Increasingly hospitals are enforcing "bare below the elbow" policies, so wrist watches are heading out.[1]

Mobile phone usage has been destigmatised in hospitals. Several "apps" have been developed for smart phones to replace the traditional handbook that would once have been tucked into white coat pockets. Smart phone usage is likely to increase, not least because of the availability of medical apps. Some hospitals have adopted wipe clean covers for computer keyboards—should we be focusing on such covers for mobile phones? Many touch screen devices have covers that can be applied after purchase. Could these be wiped with an alcohol based disinfectant, as is used on stethoscopes?

We also wonder whether the subsequent documentation of the heart rate with the clinician's pen will be another problem.

Despite the small sample size of their study, Morris and colleagues raise valid issues about the risk of spread of MRSA through doctors taking a pulse using their mobile phone, and public perception of such issues (even if taken out of context) must be carefully considered.

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Competing interests: None declared.

1 Morris TC, Moore LSP, Shaunak S. Doctors taking a pulse using their mobile phone can spread MRSA. *BMJ* 2012;344:e412. (17 January.)

Cite this as: *BMJ* 2012;344:e871

NHS REFORMS

Don't endanger health and wellbeing boards

The fury over the NHS reforms risks missing the opportunity offered by health and wellbeing boards (HWBs).[1] Marmot identified two priorities to make our health services sustainable[2]:

- Creating an enabling society that maximises individual and community potential
- Ensuring social justice, health, and sustainability at the heart of all policies.

HWBs, through their responsibility for the joint strategic needs assessment and the local health strategy, provide the opportunity for local partners to collaborate in achieving these goals.

We believe that the current central command and control structures have failed to deal with these priorities. We must enhance local social capital and community solidarity through enabling the development of individuals and communities and creating a sustainable bottom-up Big Society. HWBs have enormous potential to link health, social care, and the wider agenda of the environment and employment. They will fail if they become a centrally controlled talking shop for the great and the good. They should facilitate, challenge, and listen to community and front line voices to develop action on agreed local priorities. Local authorities will need a board chair able to foster an environment of effective and innovative local partnership, in which people and organisations are prepared to give as well as receive. The board will need to identify and ensure that local assets are developed and used cost effectively, with minimum interference, bureaucracy, and duplication.

Our current political and policy approach cannot deliver community health and wellbeing. We need to co-create the vision of self empowerment through community action. We believe this is the only way for our society to manage our increasing health needs, obligations, and responsibilities. We must develop local systems that maximise individual and community potential and ensure that social justice, health, and sustainability are at the heart of all that we do.

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On behalf of Amit Bhargava (national co-lead, NHS Alliance Clinical Commissioning Federation), Donna Kinnair (member of council, College of Medicine), Brian Fisher (patient and public involvement lead, NHS Alliance), Michael Dixon (chair NHS Alliance; chair of council, College of Medicine), Aidan Halligan (vice president, College of Medicine), Chris Drinkwater (president and public health lead, NHS Alliance), David Peters (member of council, College of Medicine), George Lewith (vice chair, College of Medicine), Cyril Chanter (member of advisory council, College of Medicine), and Graeme Catto (president, College of Medicine)

Competing interests: None declared.

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Cite this as: *BMJ* 2012;344:e876

JOE CUMMINGS

Full steam ahead onto the rocks

The bankers' SS Greed is Good may have hit the rocks and the captain been bailed out, leaving little people to suffer, yet the government follows the same market fantasy and steers the SS NHS onwards, ignoring McKee's lighthouse.[1]

To answer McKee's questions. Point one: follow the money. The corporations who fund US/UK politicians want a slice of the action.[2 3] Neoliberal economists cannot comprehend public service and believe that naked greed with free markets alone offers salvation. So markets must be created. They cannot abide billions being spent on patient care without getting their snouts in the trough.

Point two: by their fruits shall you know them. The actions speak louder than words and power is being centralised to promote markets. GP complicity is an illusion because they will be obliged to join commissioning groups or be sacked. Real power is moving away from GPs towards the health secretary and his sponsors.

Point three: Parliament is being sidelined as Lansley jumps the gun of the bill's passage and orders primary care trusts to offer up three NHS services on the altar of free market faith.[4] The experience of private finance initiative disasters, half empty independent sector treatment centres, and exploding breast implants does not shake the faith of the zealots.

Where there is no vision the people perish; Lansley shows none by replicating New Labour's commercialisation. A locally based service, under clinical direction of doctors, is receding as the bill progresses. It's full steam ahead onto the rocks.

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Competing interests: JMO is a GP principal following NHS founding principles.

1 McKee M. Does anyone understand the government's plan for the NHS? *BMJ* 2012;344:e399. (17 January.)
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Cite this as: *BMJ* 2012;344:e884

Dynamic interaction between slightly right wing minister and slightly left wing mandarins

The UK government's plans for the NHS are indeed difficult to understand.[1] What is announced, written, and discussed all seem to be quite unrelated. Cynics might see this as Orwellian: to articulate an opposition is difficult when the thing you oppose cannot itself be described. So the opponents get blamed for being confused in their opposition and, hopefully (for the government), argue among themselves.

However, the secretary of state has a very clear view of how the NHS should work. It was formed in opposition, just as that of the previous administration was. Indeed, the two government's initial plans are almost identical. For PCGs read CCGs, for "nurses and doctors in charge" read "doctors in charge." Andrew Lansley consistently promotes his vision with great clarity.

The difficulty is that the plan has to be implemented by Department of Health managers, who have a policy of "government proofing" their own vision for the NHS, which does not include a loss of power from the centre. The mandarins have therefore exerted their influence and written the Health Bill so that it enshrines the status quo but using a new language. The same thing happened to the previous government, which became so infuriated with the inertia of health authorities that it abolished them. In their cool and quiet fashion, the managers migrated into the PCTs in a process known as "shifting the balance of power," where they continued to do what they had always done before, and in greater numbers than ever before.

Understanding the plans as a dynamic interaction between a slightly right wing secretary of state and slightly left wing Department of Health is one thing, making the whole thing work is something else. I worry that those in charge are pulling in too many directions for this project to be a success.

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Competing interests: DJA is employed by several NHS organisations.

1 McKee M. Does anyone understand the government's plan for the NHS? *BMJ* 2012;344:e399. (17 January.)

Cite this as: *BMJ* 2012;344:e931

Lansley fails to see impact and damage of his reforms

Andrew Lansley seems to recognise neither the impact his pre-legislation reforms are already having on NHS service provision nor the further damage that the proposed legislation will cause.[1]

His unchanging rhetoric—"free at the point of use, and based on need and not ability to pay"—is already proved to be wrong. Foundation trusts have already introduced charges for standard operations formerly carried out for no charge. No doubt, more will follow. We have seen the shape of commissioning to come with the advent, piloted in Hertfordshire, of (ministerially approved) exclusion of people with higher body mass indices from having elective operations. The basis for this is flawed both fiscally and ethically. Shall we next exclude drunk drivers or people consuming >28 units of alcohol per week on the pejorative pretexts that "they have poorer outcomes" or "they've brought it on themselves"?

Lansley asserts that the reforms increase patient choice. In fact, patient choice has never been less than since these reforms began. The conflicting need to reduce NHS spending has resulted in much tighter controls over where patients receive their care, and measures have been introduced that restrict patients' eligibility to receive the care at all—for example, "procedures of low clinical value" such as carpal tunnel release operations, and treatments for hirsutism.

Lansley's rhetoric on empowering frontline staff shows a blatant misunderstanding of how commissioning will work. Decisions on treatment provision and care pathways will necessarily be taken long before the patient sees the doctor, and protocols will constrain clinical judgment even more than now.

Lansley misrepresents the role of privatisation in the NHS. The privatisation of hospitals is indeed privatisation as suggested by McKee[2]: why else would an investment bank (owners of Circle Health) move to take over a hospital (Hinchingbrooke)? Contrary to Lansley's statement, foundation trusts can set their own terms and conditions—for example, salaries and gagging clauses.

Most NHS staff oppose the Health and Social Care Bill, for very good reasons. In terms of who understands what the bill will mean, I think McKee does well,[3] while Lansley's adherence to narrow rhetoric fails to acknowledge the available evidence.

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Competing interests: None declared.

1 Lansley A. Why legislation is necessary for my health reforms. *BMJ* 2012;344:e789. (1 February.)
2 McKee M. Circle Health is not like the John Lewis Partnership. *BMJ* 2011;343:d7897. (13 December.)
3 McKee M. Does anyone understand the government's plan for the NHS? *BMJ* 2012;344:e399. (17 January.)

Cite this as: *BMJ* 2012;344:e926

RESPONSE

Martin McKee replies to Andrew Lansley

I thank the Secretary of State for seeking to correct my misunderstanding of the proposed NHS reforms.[1] However, his response has raised additional questions in my mind, not least because in the 24 hours since his response was published he has published almost 140 amendments to the bill. I wonder if I am alone in struggling to keep up.

I am reassured to know that the NHS will "remain free at the point of use" but am still unclear whether this covers those services, such as sexual health, that are being transferred to local government and therefore will no longer be "NHS." Will councils be able to means test them, as they did with the long term care services that they previously took over from the NHS?

I welcome the description of who is responsible for various things but note that my confusion was shared by the House of Lords Constitution Committee, which stated that "it is not clear whether the existing structures of political and legal accountability with regard to the NHS will continue to operate as they have done hitherto if the Bill is passed in its current form."[2]

I agree that there are certain things that would benefit by being made explicit but remain uncertain about why these comparatively simple matters require a bill stretching to several hundred pages. The argument that the reforms will increase the scope for frontline professionals to make decisions seems strangely at odds with a commissioning structure that replaces three management tiers with five[3] and contains a series of ministerial injunctions to "make every contact count" and, for nurses, to undertake ward rounds hourly. It is also surprising to read that patient experience in the NHS is poor, given evidence from the Commonwealth Fund that the UK is first or second among 11 countries on many measures of patient centredness.[4]

The Secretary of State offers reassurance about privatisation of commissioning and tells me that I am wrong in believing that the consortiums will be required to increase the numbers of patients treated in private facilities. I know that commissioning consortiums will be statutory bodies but read in the current draft guidance on commissioning support, which covers the operational work that they will do, that "the NHS sector, which provides the majority of commissioning support now, needs to make the transition from statutory function to freestanding enterprise."[5] Furthermore, while I am aware that the bill does not explicitly favour any provider, I read in the most recent NHS Operating Framework that one of the measures on which the National Commissioning Board will be judged is the "trend in value/volume of patients being treated at non-NHS hospitals."[6] Surely, we must expect that commissioners will respond to this clear incentive?

Finally, I remain puzzled about how the legislation is needed to give confidence to the NHS given the results of the recent YouGov poll reporting that 80% of NHS staff expressing an opinion believe that the bill should be withdrawn.[7]

I am sure that, in time, I will manage to understand the reforms. Indeed, it may be that some of the answers are contained in the torrent of amendments being introduced to clarify the intentions of the bill, although this begs the question of why, if it was all so clear, they are now deemed necessary. Sadly, I fear that, for now, my confusion is only deepening.

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Competing interests: MMcK wrote the article that the Secretary of State is responding to.

1 Lansley A. Why legislation is necessary for my health reforms. *BMJ* 2012;344:e789. (1 February.)
2 House of Lords Constitution Committee. Report on the Health and Social Care Bill. www.publications.parliament.uk/pa/ld201012/ldselect/ldconst/197/19703.htm.
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