

this week

HUNT REMAINS IN POST page 128 • **BREXIT THREAT TO SCIENTISTS** page 130



Ministers must increase NHS funding

The government will have little choice but to keep increasing spending on the NHS if it wants to maintain services and improve the nation's healthcare, experts have told peers.

If the NHS is to survive in the long term, spending must rise rather than rely on its being funded by long term efficiency saving measures, witnesses from expert think tanks told an evidence session of the House of Lords committee on the long term sustainability of the NHS this week.

Richard Murray, director of policy at the King's Fund, said that it was generally accepted that demand on the NHS would only keep growing and that people were going to live longer with more complex health needs.

Assuming that ministers and peers were not considering changing the basic position of NHS care being free at the point of use, "There aren't that many alternatives but to pay [more]," he said. "Over the next 20 to 30 years there are things that the health service might be able to do to support the growth rate, but it's quite difficult if the service is very short of staff and very short of time and money."

Nigel Edwards, chief executive of the Nuffield Trust, said, "Proximity to death is a major indicator of health spending and

we've been fortunate in many ways over the last four decades that the death rate has been falling. It's now about to start rising for the next 40 to 50 years as the 'baby boomer' generation comes through."

This week a report by the House of Commons Health Committee warned that the NHS's five year plan to transform health and care services in England is being jeopardised by cuts to public health, education and training, and social care.

The report said that while the government's 2015 spending review agreed to increase the NHS budget by an additional £8.4bn a year above inflation by the year 2020-21 (£7.5bn in real terms), unlike previous reviews the 2015 review just included the budget for NHS England and excluded funding for public health and education and training.

The BMA's chair of council, Mark Porter, said that the MPs' report offered "another stark warning" about the financial crisis in the NHS. "Without significant funding to tackle obesity, alcohol abuse, and smoking, it will be impossible to implement the public health measures set out in the *Five Year Forward View* that are fundamental to maintaining an affordable NHS," he said.

Adrian O'Dowd, London [Cite this as: BMJ 2016;354:i4035](#)

BMA's chair of council, Mark Porter: "Without significant funding, it will be impossible to implement the public health measures set out in the *Five Year Forward View*"

LATEST ONLINE

- NHS England unveils plans for mental health reform
- Brexit may hamper introduction of seven day services
- Pooled general practices do not improve quality of care



SEVEN DAYS IN



DAN KITWOOD/GETTY IMAGES

Hunt holds on to health secretary post

Jeremy Hunt will remain health secretary for England despite a flurry of rumours that he would be sacked or at best transferred to another position.

His reappointment is seen at Westminster as a strong signal of support for Hunt's long running disagreement with junior doctors over a new contract. Whatever his personal wishes may have been, the new UK prime minister, Theresa May, recognised that moving him would signal a lack of conviction in the dispute and embolden fresh industrial action by doctors who voted against a deal struck between Hunt and the BMA.

"Reports of my death have been greatly exaggerated," tweeted Hunt after his reappointment. "Thrilled to be back in the best job in government."

On the morning of Thursday 14 July Hunt had undergone death by Twitter, as a series of tweeters, led by the BBC's political editor, Laura Kuenssberg, predicted his demise. "Jeremy Hunt also out" she tweeted at 11.10 am, modifying the message at 11.20 am, when she tweeted, "Hunt not sacked, getting a different job."

If Hunt's reappointment signalled no change in government attitudes towards the junior doctor contract dispute, May's own remarks on economic policy might be seen by some as indicating that the squeeze on NHS funding will be eased. She has indicated that the policy of getting the budget deficit down, pursued by the former chancellor, George Osborne, is no longer a top priority.

Nigel Hawkes, London [Cite this as: BMJ 2016;354:i3946](#)

Politics

May appoints new ministerial team

The prime minister, Theresa May (below), continued her reshuffle by appointing three new health ministers. Joining Jeremy Hunt, who keeps his role as health secretary for England, are: Philip Dunne, who moves from the Ministry of Defence; Nicola Blackwood, chair of the science and technology committee; and David Mowat. Their full portfolios have not yet been announced. Lord Prior remains as undersecretary of state for health. (Full story doi:10.1136/bmj.i3986)



NHS spending

Test for pregnant women could save NHS £500 000 a year

A new test for rhesus D negative pregnant women could save the NHS £500 000 a year. Draft guidance from the National Institute for Health and Care Excellence recommends that

only women carrying a rhesus D positive baby should be treated with anti-D immunoglobulin. If the proposal is adopted, treatment could be avoided in 40 000 women, NICE said. (10.1136/bmj.i3944)

NHS must rein in specialised services spend, MPs warn

Disproportionate growth in spending on specialised health services in England puts wider NHS finances at risk, MPs warned. The House of Commons public accounts committee said that NHS England would need to make "tough decisions" to stay within its budget for specialised commissioning in the future, after spending increased from £13bn to £14.6bn from 2013-14 to 2015-16. (10.1136/bmj.i3948)

Child health

Frozen tissue offers fertility hope to boys with cancer

Scientists at Edinburgh University developed a service to store



testicular tissue from boys as young as 1 who are at risk of infertility. The MRC Centre for Reproductive

Health offers a service to pre-pubertal boys undergoing cancer treatment, which involves taking a biopsy of testicular tissue and cryopreserving it. The team is currently carrying out research on how to turn the immature testicular tissue into sperm cells. (10.1136/bmj.i3955)

Fracking

Fracking linked to asthma flare-up

A study in *JAMA Internal Medicine* has found an increased number of asthma exacerbations in areas where fracking—a controversial method of gas extraction—takes place. The authors identified 20 000 mild, nearly 2000 moderate, and 5000 severe asthma exacerbations. (Full story: 10.1136/bmj.i3992)



Regulation

GMC introduces fitness to practise changes

The General Medical Council launched two pilot schemes to speed up fitness to practise cases and reduce their impact on doctors. For doctors who have made a one-off mistake the council will review key information before deciding whether to open a full investigation. The second scheme is designed to protect whistleblowers, as employers will disclose whether there have ever been patient safety concerns related to the doctor involved.

Surgeons oppose release of mortality figures

Most surgeons oppose the publication of surgeon specific mortality data. A survey of 264 consultant cardiothoracic surgeons in the UK—73% of the total—found that 58.1% opposed release of the data, while 34.1% were in favour. They said that publication could lead to risk averse behaviour among surgeons, gaming of data, and misinterpretation of data by the public.

MEDICINE

Children's obesity

Mobility improves in teens after bariatric surgery

Severely obese teenagers who undergo bariatric surgery have improved mobility, a study in *JAMA Pediatrics* found. The study of 206 US adolescents with an average body mass index of 51.7 found that the time to complete a 400 m walk significantly improved six months after surgery, from an average of 376 seconds to 347 seconds. Resting heart rate also improved from an average of 84 beats per minute to 74 beats per minute.

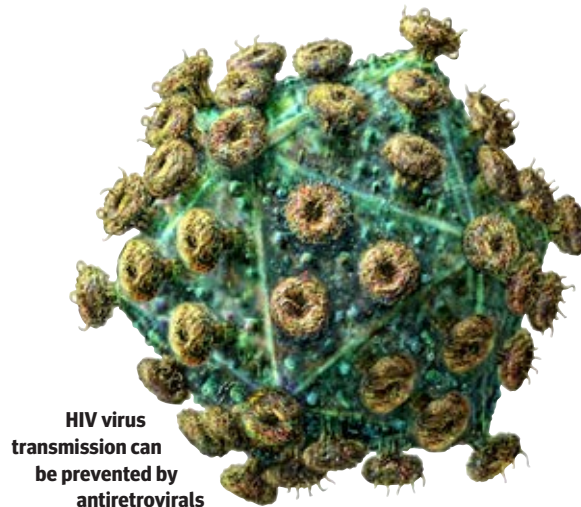
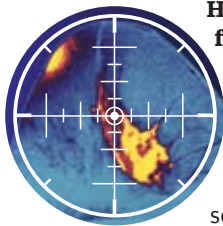
Obesity strategy is postponed again

The *Financial Times* and the *Times* reported that the long awaited government white paper on child obesity, due this month, may be delayed until the next parliamentary session. Several newspapers had seen a draft of the document and reported that it had been watered down after lobbying by industry. Some measures, such as asking retailers to stop promotion of unhealthy food and asking food producers to reduce sugar, will not be mandatory.

Targets

Cancer targets are missed

NHS England missed its target of ensuring that 85% of patients with cancer begin treatment within 62 days of urgent referral by a GP. Figures from May, released this month, showed that 81.4% of patients began treatment within 62 days. The two week waiting time target for patients with breast cancer was also missed: 92.1% were seen by a consultant within two weeks of referral, 0.9% short of the 93% target.



HIV virus transmission can be prevented by antiretrovirals

Sexual health

Antiretrovirals prevent HIV transmission from unprotected sex

Gay men and heterosexual people with HIV taking antiretroviral drugs do not transmit the virus to their partner, even from sex without a condom, research found. The *JAMA* study of 548 heterosexual couples and 340 gay male couples who reported having sex without a condom found no transmission of the disease within the couples after a median of 1.3 years.

Health experts call for full decriminalisation of prostitution

Public health experts backed a report by the home affairs select committee calling for changes to the law to make soliciting legal. Pippa Grenfell, research fellow in public health sociology at the London School of Hygiene and Tropical Medicine, urged the full decriminalisation of sex work. "In New Zealand, full decriminalisation has led to better working conditions for sex workers, including improved capacity to negotiate condom use and refuse clients," she said. (10.1136/bmj.i3927)

Cite this as: *BMJ* 2016;354:i4011

MISSED DRUG DOSES

A *British Journal of Clinical Pharmacology* study of 503 adults aged 80 years and over found

that **67%** of patients were underusing medicines and **56%** were taking them incorrectly



SIXTY SECONDS ON... MEDICAL MARIJUANA



STONE ME, WE'RE TALKING ABOUT MEDICAL MARIJUANA?

Yes, it's high on the agenda because of a study showing that US states that have sanctioned it for medical use have seen rates of prescribing for certain drugs plummet.

THAT'S DOPE, MAN! WHICH TREATMENTS SAW THE BIGGEST DROP?

Demand for pain relief benefited most. Doctors in states that offer medical marijuana prescribed 3644 fewer doses a year on average (28166, compared with 31810 in states where the drug isn't offered). Rates of prescribing of drugs for anxiety, depression, nausea, psychosis, and sleep disorders were also lower, by 8% to 13%.

HOW DO I GET MEDICAL MARIJUANA? FOR RESEARCH PURPOSES, OBVIOUSLY

In the US 25 states have legalised marijuana for medical use. Most doctors can't prescribe but can recommend it for certain conditions such as chronic pain, spasticity, and glaucoma. Patients then buy the drug from legally protected dispensaries.

ANY DOWNSIDES?

States that have legal dispensaries have higher rates of marijuana dependence, as indicated by referrals to treatment, than states that don't have them.

HIGH TIME IT WAS LEGALISED FOR MEDICAL USE IN THE UK?

UK law does not see medical marijuana as having any therapeutic value, and therefore it is not licensed for use here. In 2006 the Home Office approved a cannabis based product called Sativex for patients with spasticity associated with multiple sclerosis.

WHAT A DOWNER

Yes, especially as legalised cannabis raises a lot of money in taxes. A report commissioned by the Liberal Democrats found that legalising cannabis could raise as much as £1bn a year in taxes in the UK.

A FIX FOR THE DEFICIT, SURELY?

The Lib Dems were thinking of including the policy in their next manifesto but, you know, just couldn't be bothered, man.

Anne Gulland, London

Cite this as: *BMJ* 2016;354:i3962

Meningitis B vaccination is not extended to 2 year olds

The Joint Committee on Vaccination and Immunisation has rejected a call for the meningitis B vaccination programme to be extended.

The committee said that there was not enough stock of the vaccine to be able to include children aged 12 to 23 months. The vaccination was introduced into the routine programme for babies under the age of 12 months last year.

Potentially cost effective

The minutes of the joint committee's June meeting,



published on 13 July, said that while "wider use of the vaccine would be desirable from a public health perspective" and

that "a programme to vaccinate children aged 12-23 months of age could be cost-effective," vaccinating those aged 24 to 47 months was "unlikely to be cost effective," and vaccinating those aged 48 months to 11 years of age "was highly unlikely."

But insufficient vaccine

However, the committee said there was unlikely to be enough vaccine to give to children over the age of 12 months before the 2016-17 meningococcal season. The committee said use of Public Health England's buffer stock would pose a risk to the current meningitis B vaccination programme.

"Given these concerns the committee agreed that they could not advise the Department of Health to consider such a catch-up programme," the committee said.

Campaigners have been calling for the vaccine to be made available to all children under 5.

Anne Gulland, London

Cite this as: *BMJ* 2016;354:i3943

Haiti's health system collapsing under weight of doctors' strike

In Haiti a medical residents' strike, hospital closures, and a lack of basic medical supplies have left millions of patients with no healthcare.

Most of the country's public teaching hospitals have shut down and many staff are downing tools in sympathy with the striking residents, who earn just 7000 Haitian gourdes a month (£85), rising to a possible 9000 gourdes.

Among the closed hospitals is the country's largest, Port-au-Prince's Hospital of the State University of Haiti (HUEH), known locally as the General Hospital. Strike action began there in March when the hospital's administrator allegedly slapped a resident during a dispute over a delayed test for a patient.

"None of the public hospitals around the country are functioning and no one is saying anything," HUEH's executive director, Maurice Fils Mainville, told the *Miami Herald*.

The strike soon turned into a nationwide residents' walkout, with strikers demanding pay rises, safer working conditions, and a reliable supply of basic medical equipment, such as syringes and oxygen.

Heavy foreign investment since the 2010 earthquake has produced few improvements in the health system, with donors focusing on single disease campaigns or prestigious building projects rather than primary care and

sustainability, local doctors said.

A \$30m public hospital built by Canada was known locally as a white elephant before the strike closed it down, and a \$83m general hospital being built by France and the US faces an uncertain future since no funds were set aside for its operating costs.

"Rotting system"

The work of the American Red Cross in Haiti was also criticised in a US congressional report last month that accused the organisation of having little to show for its spending because of poor accounting and excessive claims for overhead costs.

With most of Haiti's health budget already consumed by doctors' pay, the gap between the residents' demands and the government's capacity to pay looks unbridgeable. Two weeks ago health minister Gabriel Timothé offered to double the salaries of all residents. But the salary offer of 14 000 to 17 000 gourdes a month was only half of the lowest of the residents' demands, and less than a fifth of the 80 000 gourde starting salary demanded by strikers at most hospitals.

"This rotting system is either going to totally collapse or it's going to have to improve," resident Rishkord Juin, a strike leader, told the *Miami Herald*. "We don't want the hospital to turn into a morgue. If we're



"None of the public hospitals around the country are functioning"



Government acts on EU bias claims

The UK government has created a unit to gather evidence of bias against scientists and researchers in the UK after the referendum decision to leave the European Union.

During an evidence session of the House of Commons Science and Technology committee held on 13 July, MPs asked about reports that

some scientists in the UK who were already part of a European consortium were being asked to leave or were made to feel unwelcome because some scientists in other European countries assumed that the UK no longer wanted to be part of Horizon 2020, Europe's largest research and innovation funding programme.

Jo Johnson (left), minister for universities and science at the Department for Business Innovation and Skills, giving evidence, tried to reassure the committee. He said, "We have been very clear that there should be no discrimination against UK institutions, soft or hard. We've made representations to Carlos



The strike was sparked when a resident was slapped at the General Hospital in Port-au-Prince

DIEU/NALIO CHERY/AP/PA

going to work there, it has to be under good conditions.”

Doctors are also demanding medical insurance for themselves and for police to patrol hospitals to protect them from often violent, armed patient relatives.

The Haitian Medical Association has asked the parties to resume dialogue, but said two weeks ago that “all the bridges seem to have been burned.”

Waning public support

Since last month, the country has been leaderless, as the mandate of interim president Jocelerme Privert expired and lawmakers have refused to meet to extend it. Haiti has been deadlocked in a contested election process since last year.

Initial public support for the doctors has waned. The death of a pregnant woman who pleaded for entry at

the gates of Port-au-Prince’s general hospital led to a public demonstration, with the crowd chanting “Medicine must work” as they carried the woman’s body to a local radio station.

Two hospitals run by non-governmental organisations (NGO) have been flooded with patients since the public system broke down. Médecins Sans Frontières runs an orthopaedic trauma hospital in Tabarre, and, in view of the health situation, the group recently decided to extend its stay in Haiti by 10 years. They are now limiting care to open fractures, in which bone projects from the wound, only. Patients with closed fractures are splinted and discharged with referrals for public hospitals that will no longer take them.

Owen Dyer, Montreal

[Cite this as: BMJ 2016;354:i3939](#)

Moedas, the European commissioner for research, science, and innovation, and have sought his reassurances, which he has provided.

“At our request, he put out a statement reassuring UK researchers that their validity for Horizon

2020 applications remains unchanged.”

Johnson said that he was “extremely concerned” at the anecdotal reports of discrimination, such as UK institutions hearing that European institutions were no longer willing to partner them. He said, “We have

asked institutions to provide us with concrete evidence where this is happening, and we have set up in the department a unit that is ready to receive such evidence.” Any examples of this sort can be sent to: research@bis.gsi.gov.uk.

Adrian O’Dowd, London

[Cite this as: BMJ 2016;354:i3932](#)

HORIZON 2020 Nearly €80bn of funding made available over seven years (2014 to 2020)

FIVE MINUTES WITH . . .

David Gilbert

The first patient director in the NHS reflects on his role a year on from his appointment

“Sussex Musculoskeletal Partnership (Central) made this role part of the executive team, alongside the clinical and managerial directors. They wanted someone who’d experienced a life changing illness or disability. I’m a former mental health service user.

“The role is about having the authority to support patient centred stuff to happen. I oversee work on improving patients’ experiences, patient and public engagement, self management support, and patient facing communication—things usually managed in different silos.

“I don’t ‘represent’ patients but try to open the door for others. Engagement is a collective responsibility. But I can help and make connections to make it happen.

“We have agreed three CQUINS [commissioning for quality and innovation payment framework] with our clinical commissioning groups. They cover pain service redesign, improving shared decision making, and outcomes that matter to patients.



“Patient partners will co-design these improvement projects, as well as other engagement work within the projects. Soon we will also have patient partners on the multidisciplinary teams for our clinical pathways.

We have to value people’s contributions, and patient partners will get support, training, and money: £150 a day.

“Patients aren’t there just to tell their story or to be ‘representatives.’ They are questioners, critical friends, helpers, supporters, advisers, and ideas people. Above all, they are equals.

“The first year has been about building relationships and getting systems and processes into place. There are tangible improvements too. We worked with patients and clinicians to improve appointment letters. We cut back the ‘shouty’ language. We also added questions they might want to think about before they come in.

“What gives me the most hope and joy is seeing relationships developing between patient partners, clinicians, and other staff. It’s not easy, but it is certainly worthwhile. Soon having a patient director will be the norm.”

To read David Gilbert’s blog go to www.futurepatientblog.com.

[Cite this as: BMJ 2016;354:i3689](#)



Progress towards goal to end HIV epidemic falters

AIDS activists were joined by US actor and singer Queen Latifah (wearing hat) at an anti-AIDS march in Durban, South Africa, which is this week hosting the International AIDS Conference. World leaders at the conference expressed fears that the UN goal to end the HIV and AIDS epidemic by 2030 will not be met, owing to declining funds and the failure to reduce numbers of new infections in adults.

Almost 37 million people are still living with HIV, 20 million of whom do not have access to lifesaving drugs. A UNAIDS report found that the incidence of HIV among adults had not declined for at least five years.

The secretary general of the United Nations, Ban Ki-moon, said that despite the transformation brought about by generic formulations of antiretrovirals, gains had been “inadequate.”

Sophie Cousins, freelance journalist, Durban

thebmj.com

• News story in full (*BMJ* 2016;354:i4025)



RAWESHJANTILAJ/AP/GETTY IMAGES

Funding PrEP for HIV prevention

Delays by NHS England will cost lives—it's time to do the right thing

Despite overwhelming evidence that pre-exposure prophylaxis (PrEP) against HIV infection is largely safe, effective,¹⁻⁴ and cost effective,⁴⁻⁷ NHS England has declined to make it available on the NHS, arguing that HIV prevention is the responsibility of local government.⁸

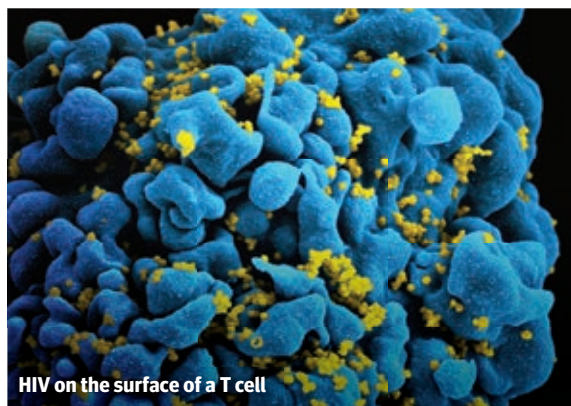
NHS England's apparent appetite for legalistic cost shunting,⁹ and its argument that it does not have the legal power to commission PrEP,⁸ is regrettable. Such an approach confounds its advocacy of a health and care system integrated around the best outcomes for the citizen and perpetuates an incoherent national approach to HIV prevention.

PrEP has undoubtedly attracted some moral panic.¹⁰⁻¹¹ Yet the clinical principle is not dissimilar to that of antimalarials, used to prevent malaria when travelling in at-risk environments. In population health, PrEP's role is comparable to the function of vaccinations and immunisations, which NHS England does fund.

HIV risks do not just have personal health consequences. By taking PrEP, people at high risk of HIV infection substantially reduce population spread.¹²⁻¹⁴ Prophylaxis cuts the risk of the virus entering cells and replicating, and helps prevent people becoming vectors for further transmission.

Treatment as prevention

Although PrEP is not 100% effective, the US Centers for Disease Prevention and Control is unequivocal about its population health benefits.¹⁵ Studies show that PrEP reduces the



HIV on the surface of a T cell

NMAD/SPL

risk of getting HIV from sex by more than 90% when used consistently.¹⁶ Among people who inject drugs, PrEP reduces the risk of getting HIV by more than 70% when used consistently.¹⁷ PrEP is a key reason why “treatment as prevention” is an attractive strategy to reduce or even end HIV transmission.¹⁸ As increasing numbers of commentators claim, the long term fiscal and health benefits of treatment as prevention strategies, including PrEP, will return substantial dividends for health systems.¹⁹

In the US many citizens now access PrEP through health insurance plans or for free via charity or voluntary sector agencies, but Europe languishes in indecision. Temporary orders in France enable some access, while private purchase, often online, remains a primary route in England. Clearly, this route is open only to those who can afford it.

NHS England has at least adopted a clinical policy of treatment as prevention for adults already infected,²⁰ but England still lacks a coherent strategy to eliminate HIV or achieve the UNAIDS 90-90-90 aspirations that “by 2020, 90% of all people living with HIV will know their HIV status ... 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy [and] 90% of all people receiving antiretroviral therapy will have viral suppression.”²¹

NHS England should admit that it can legally fund PrEP if it wants to

PrEP has now been referred to the National Institute for Health and Care Excellence (NICE), and NHS England has put £2m into a pilot for a few areas “to research how PrEP could be commissioned in the most clinically and cost effective way.”²² This has been widely criticised as a delaying tactic.²³

Competitive investment

NHS England should admit that it can legally fund PrEP if it wants to. Under the Health and Social Care Act 2012, it can commission services directly with “specialised commissioning investment” after consideration of several factors, including “the number of individuals who require the provision of the service or facility; the cost of providing the service or facility; the number of persons able to provide the service or facility; and the financial implications for clinical commissioning groups.” PrEP should be allowed to compete on a level playing field against all other candidate interventions for such specialised commissioning investment.²⁴

Local authorities are still reeling from a 9.6% cut in the public health grant up to 2020 on top of a 6.2% cut in year in 2015-16, which the Treasury imposed in November 2015 with no reductions in delegated responsibilities. If NHS England wants local authorities to fund PrEP, it has to give them the money to do it.

Whatever route is finally chosen to fund PrEP, bouncing the decision across systems that are all funded by the same taxpayer will inevitably result in the continued and preventable further spread of HIV. This will generate avoidable mortality and increase future NHS costs for treatment. Perhaps it is time for NHS England just to “do the right thing.”

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Challenges for the new cabinet's health secretary

Valuing staff and supporting them to improve care should be the priority

The immediate challenge facing Jeremy Hunt, who has been reappointed as health secretary in the new Cabinet, is to confront the parlous state of NHS finances in England. The aggregate deficit of £1.85bn in 2015-16 was the largest in NHS history and resulted from increasing demands on providers at a time of constrained funding.¹

Almost all of last year's deficit was concentrated in acute hospitals and was driven by the appointment of additional clinical staff, many recruited from agencies, in response to the failures of patient care at Mid Staffordshire NHS Foundation Trust² and concerns about Care Quality Commission inspections. The regulator of NHS providers, NHS Improvement, has intervened to control the costs of agency staff and has signalled that providers should cut the number of clinical staff they employ to restore financial balance.³ Unless managed carefully, staff cuts could compromise patient safety and the quality of care.

One of the consequences of overspending in acute hospitals is that most of the extra funding available in 2016-17 is being used to reduce their deficits. Little will be left over to fulfil commitments to increase spending on mental health services and general practice, or to cover the costs of new priorities such as implementing seven day services. There are also concerns that raids on capital budgets to reduce deficits are storing up problems for the future through cuts in maintenance of buildings and reduced investment in new facilities.

Chris Ham, chief executive, King's Fund, London, UK C.Ham@kingsfund.org.uk

Collaboration rather than competition holds out the best chance of the NHS and its partners navigating the treacherous waters that lie ahead

Equally troublesome are cuts in public health budgets and insufficient funding of social care. Social care leaders have warned that services are at breaking point after several years of cuts.⁴ A fundamental realignment of spending on health and social care is growing more urgent.⁵

The number and scale of the challenges facing the NHS and social care may help explain why Jeremy Hunt has returned to the Department of Health. A new health secretary would have needed time to master the brief, and the prime minister clearly decided time was at a premium in taking action to stabilise NHS finances and performance. Further, Hunt's willingness to take a firm stance over the proposed junior doctors' contract echoes her confrontation of the police service.

Scope for change

Hunt's room for manoeuvre in addressing these challenges is limited, with NHS Improvement and NHS England's plans to reduce deficits and improve performance at an advanced stage. Just as important is the close involvement of the Treasury, which has had increased influence over the NHS as finances have deteriorated. Early indications are that the government is willing to borrow and spend to deal with the economic

consequences of Brexit, but this is money is likely to go on infrastructure

projects rather than revenue spending, which is where the main pressures are being felt in health and social care.

Political realism about what the NHS is able to deliver is a necessary first step in facing up to the consequences of continuing austerity, painful as this may be. This means avoiding making new commitments that cannot be funded and deciding which existing commitments—for example, on waiting times—matter most. As well as realism about the state of the NHS funding and performance, the health secretary should have three other priorities.

The first is to rebuild bridges with NHS staff, especially junior doctors, after the damaging dispute over the new contract. Leaders at all levels urgently need to show that staff are valued, and this must start at the very top of the NHS. Not penalising NHS leaders who are struggling to achieve targets for patient care and balance budgets in increasingly difficult circumstances must be part of this.

A second priority is to support staff to bring about improvements in care and make better use of resources by focusing on changes in clinical practice. Ongoing work by clinicians to tackle unwarranted variations in care requires the visible support of Treasury and health ministers.

Finally, the health secretary should continue to support work to implement new models of care better suited to the needs of the population and to produce sustainability and transformation plans in 44 areas of England.⁶ Some areas are beginning to show how care can be transformed through clinical integration and by organisations working together to plan for the future. Collaboration rather than competition holds out the best chance of the NHS and its partners navigating the treacherous waters that lie ahead.

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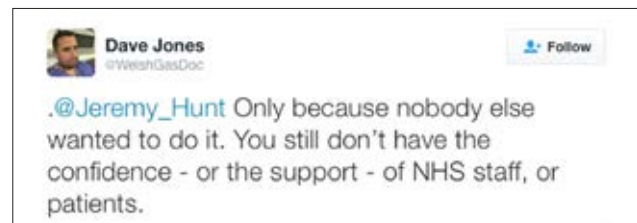
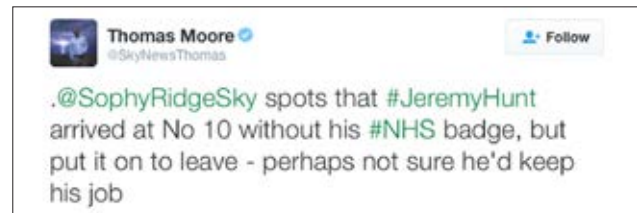
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THE DEBATE ONLINE AT THEBMJ.COM

He's still here

There was speculation last week that Jeremy Hunt would be sacked as health secretary. In the end, Prime Minister Theresa May decided to keep him in post. Needless to say, May's move triggered a lively response on Twitter.



What should Hunt do next?

Gareth Iacobucci gets the profession's reaction to Jeremy Hunt's reappointment as health secretary

"Reports of my death have been greatly exaggerated... Thrilled to be back in the best job in government."

After a frantic morning at 10 Downing Street last week, during which some media were forced to hastily withdraw the news that he had been removed from his post, Jeremy Hunt cheerfully channelled Mark Twain to confirm that Britain's new prime minister, Theresa May, had decided that he would remain in the role he has held since September 2012.

Did May admire the tough stance Hunt had adopted during the junior doctors' dispute (possibly, given her handling of the Police Federation while serving as home secretary)? Was he being asked to clean up his own mess with regard to the junior doctors' contract? Or was he simply the safest pair of hands?

May's reasons remain hidden for now, but Hunt insisted he had asked to stay on. The retention of their *bête noire* provoked immediate chagrin among junior doctors, including Oxford junior doctor Rachel Clarke, who accused the health secretary of "alienating, demoralising, and insulting a generation of young doctors."

Clarke, who has been a vocal opponent of the new contract, says that the only way that Hunt can begin to regain the profession's trust is by halting its imposition and acknowledging the true cost of a seven day NHS.

"That means, first and foremost, being honest with us and with the public [that] his government's paper-thin 'commitment' to a seven day NHS... is backed up by neither the funds nor staff that make its delivery possible. Until Jeremy Hunt is honest about that, there's not a doctor in the country who will respect or trust him."

Chris Ham, chief executive of the health think tank the King's Fund, says the government must accept the need to review current priorities and

avoid new commitments that cannot be funded.

"He [Hunt] is on record as saying the NHS will need more money, and he must now lead an honest debate with the public about what the health service can deliver with its budget," says Ham.

Neena Modi, president of the Royal College of Paediatrics and Child Health, believes the UK's vote to exit from the European Union offers Hunt an opportunity to withdraw his imposition of the new contract and thaw relations with junior doctors.

"In one fell swoop he could say, 'The EU referendum has changed the landscape. I accept that this has been deeply damaging, let's try to start again.' What a wonderful gesture that would be," Modi tells *The BMJ*.

Chaand Nagpaul, chair of the BMA's GP committee, offers two pieces of advice for Hunt: "Firstly, given financial and workforce constraints, politics must not rule how money and resources are used in the NHS. Secondly, the government must be open about the fact that the NHS needs more resources and find ways to resource it properly."

Financial pressure

With May vowing to lead a government that works not just for the "privileged few,"⁶ the Royal College of Physicians' president, Jane Dacre, believes there may be an opportunity to push for a better settlement for the "underfunded, underdoctored, and overstretched" NHS.

"I have heard that Jeremy Hunt and Simon Stevens got

He must now lead an honest debate with the public about what the NHS can deliver

the best [NHS funding] deal they could at the time. But it was a time when there weren't very many good deals to be had," says Dacre.

"It would be nice if the new prime minister—with an approach that supported everybody in the country rather than just the elite—might recognise that the sick people who need the NHS are worthy of an increased percentage spend [of gross domestic product on healthcare]."

Modi is more pessimistic. "Can there be any sense in driving the NHS into such an enormous financial hole and simultaneously treating the junior doctors as it has if the government isn't simply trying to hasten the demise of the NHS?" she asks.

"If the government doesn't want to do that, then let's hear that with clarity."

As well as overcoming such scepticism, Hunt must tackle immediate pressure on hospitals that threatens to catapult the NHS on to the front pages of the newspapers.

Clare Marx, president of the Royal College of Surgeons, says Hunt's focus should be on reducing waiting times in emergency departments and for elective surgery, and on dealing with delayed transfers of care and the underfunding of social care.

The BMA's chair, Mark Porter, says Hunt's urgent priorities should be to tackle "the serious funding shortfall" in the NHS as well as recruitment and retention problems.

Hunt is at least up to speed on these longstanding issues. "He knows the patch, he knows the issues, he knows what the problems are," says Dacre, who cites rota gaps as "the single biggest thing" affecting doctors' morale in hospitals.

"What I would like him to do is to work effectively with us to find the best solutions."

Gareth Iacobucci, news reporter, *The BMJ*

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EDITORIAL, p 135; DIGITAL HIGHLIGHTS, p 136



Wellbeing and being well

John Appleby looks at the correlation between health and happiness

What does being healthy mean? What it does not mean—according to the well worn World Health Organization definition—is the absence of disease.¹ More positively than that, as the WHO definition clarifies, health is a “state of complete physical, mental, and social wellbeing.” This classic definition of what it means to be healthy is great—as far as it goes. But what does wellbeing mean? And—at the risk of getting into a definitional loop—is wellbeing essentially the same as being well?

Traditional, largely economic measures—gross domestic product, unemployment rates, etc—have long been recognised as providing only a partial picture of a nation’s progress or wellbeing. But since 2011 (and following an early commitment by the coalition government in 2010²) the Office for National Statistics (ONS) has reported on an annual UK-wide survey covering around 160 000 members of the public designed to elicit views about their wellbeing.^{3,4} The survey asks about satisfaction with life, the extent to which the things they do in life are worth while, and how happy and how anxious they feel (box). It also gathers data on personal characteristics and self assessed ratings of health. Data from these subjective surveys of individual wellbeing are now increasingly combined with more traditional measures to provide an overview of national wellbeing.⁶

Trends in three wellbeing measures show statistically significant improvements over the five years to 2015-16. However, the latest survey suggests that ratings for life satisfaction and doing things in life that are worth while have remained statistically unchanged in 2015-16 compared with 2014-15. Whether the increase between these years is meaningful remains moot (fig 1).

Location, location, location

There are also statistically significant differences in levels of wellbeing between population groups. Perhaps surprisingly (though the correlates of happiness are not always straightforward), Northern Ireland recorded the highest happiness levels of the four UK countries in 2015-16 (fig 2). Within England, the East Midlands was significantly happier than the North East. And across age groups, happiness levels reduce for 16-24 year olds to a nadir for 45-54 year olds before rising to a peak for 65-74 year olds and then falling again for older age groups. Again, whether the absolute differences—for example, around 0.2 (on a 0 to 10 scale) at the extremes for regional variations—are meaningful or important is moot.

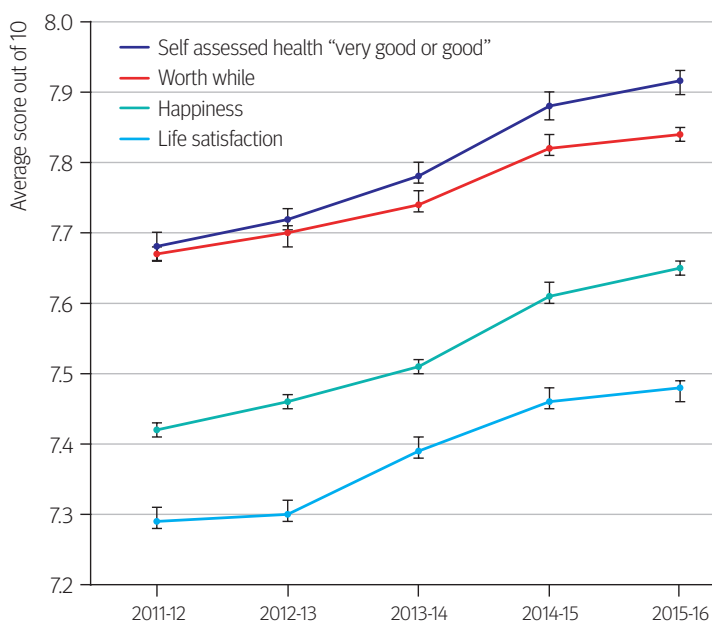


Fig 1 | Trends in measures of wellbeing and self assessed health in UK, 2011-12 to 2015-16 (95% confidence intervals). Anxiety also improved significantly, falling from an average score of 3.1 in 2011-12 to 2.9 in 2015-16⁵

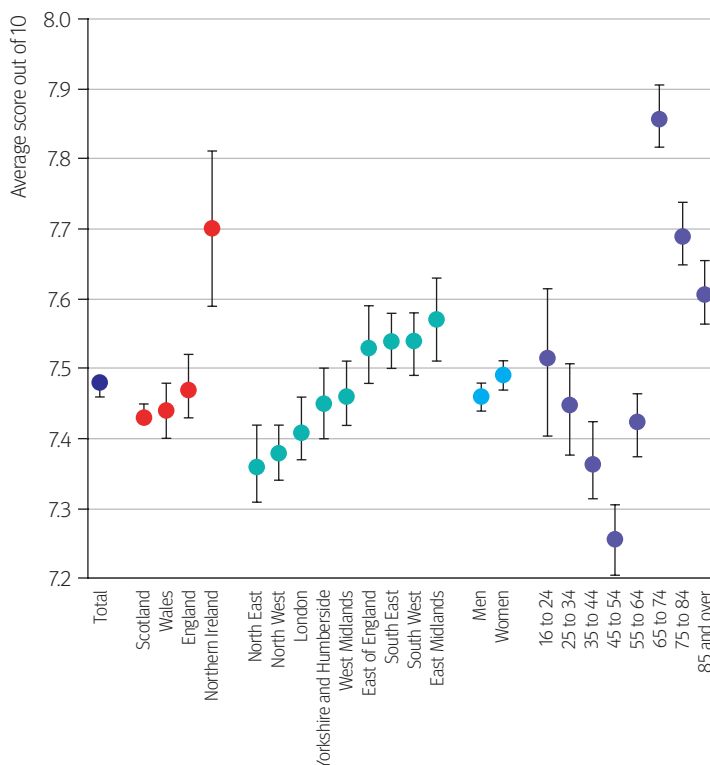


Fig 2 | Happiness ratings from 0 (worst) to 10 (best) by UK region, sex, and age group in 2015-16 (95% confidence intervals)⁵



CULTURA CREATIVE/LAWNY

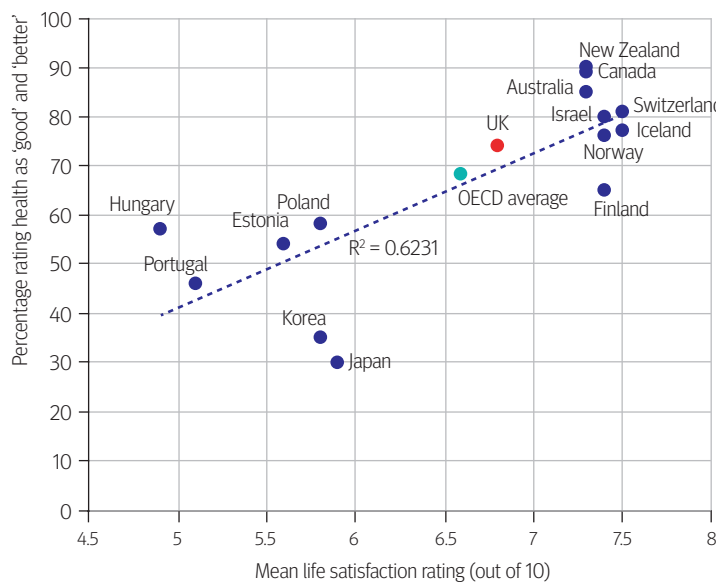


Fig 3 | Association between self assessed good health and life satisfaction in selected countries in the Organisation for Economic Cooperation and Development (OECD), 2014⁷

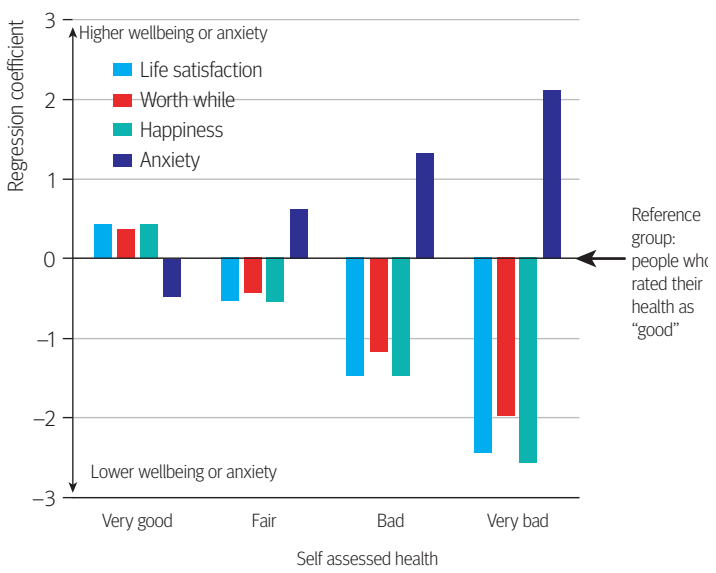


Fig 4 | Association between self assessed health (with those reporting “good” health as the reference) and four measures of wellbeing, UK, 2011-12⁸

UK NATIONAL WELLBEING SURVEY QUESTIONS⁵

Life satisfaction—Overall, how satisfied are you with your life nowadays? Where 0 is “not at all satisfied” and 10 is “completely satisfied”

Worth while—Overall, to what extent do you feel the things you do in your life are worth while? Where 0 is “not at all worth while” and 10 is “completely worth while”

Happiness—Overall, how happy did you feel yesterday? Where 0 is “not at all happy” and 10 is “completely happy”

Anxiety—Overall, how anxious did you feel yesterday? Where 0 is “not at all anxious” and 10 is “completely anxious”

But what underlies these differences and trends in wellbeing? International comparisons of life satisfaction suggest that people’s health (as they assess it) is positively associated with their ratings of satisfaction with life (fig 3⁷). And as fig 1 shows, trends in wellbeing measures are mirrored by similar trends in the UK’s average self assessed health rating.

These suggestions turn out to be an indication of a more solid relation between wellbeing and being well. A study by the ONS controlling for other factors thought to influence levels of wellbeing shows a definite and significant relation between wellbeing and health.⁸ As fig 4 shows, relative to those rating their health as “good,” lower ratings on four wellbeing measures are correlated with poorer levels of self assessed health (the reverse for anxiety). In fact, of the factors tested by the ONS study, self assessed health was the most influential.

It would seem that improving individual, and hence national, wellbeing might best be achieved through improving people’s health. Whether this would be more cost effective than, say, improving people’s earnings (positively correlated with life satisfaction) remains to be seen.

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Workforce gaps are result of reorganisations and “quick fixes,” says Health Foundation

The NHS workforce in England has swung from boom to bust because of repeated reorganisations and a reliance on “quick fixes” to solve deep systemic problems, the Health Foundation has said.

A study by the charity has concluded that “mismatches” between funding and staffing levels and top-down system reforms have undermined any long term consistency in workforce planning. At the same time lower cost “quick fixes” have placed a “sticking plaster” on deep seated systemic difficulties.

The foundation has called for a more coherent, sustainable approach to tackling funding constraints and staff shortages. It said that these constraints and shortages posed the “greatest threats” to the delivery of the NHS *Five Year Forward View*.

The authors said that “more targeted and aligned” policies were needed regarding retention, temporary staff use, and international recruitment to tackle current and future skills shortages in the short term. They concluded, “This will buy time for more effective and sustained responses to skills shortages and staffing to be implemented.”

The report, entitled *Staffing Matters; Funding Counts*, examined trends and features of the NHS workforce in England and specific “pressure points.” These pressure points included the recruitment and retention



of GPs, international recruitment to fill vacancies, and the use of temporary and agency workers.

The Health Foundation said that attempts to recruit from abroad and cap temporary staffing costs showed that national and local leaders were trying to use “less costly, reactive, and short term solutions” to tackle staff shortages. Few “top-down” NHS system reforms have given detailed consideration to workforce implications, and national policy changes have focused on saving money, it said.

The report noted that the health service’s workforce problems owed more to “poor strategic coordination

A coherent sustainable approach to tackling staff shortages is needed

and conflicting political, funding, and planning objectives and cycles” than to technical shortcomings in planning. This “recurring theme of mismatches between staffing and funding” must be tackled, it said.

The authors commented that national policy and planning must consider the needs of the health system workforce “holistically” and have a full understanding of labour market dynamics. They wrote, “In simple terms, it is not just about training more workers.”

The analysis showed how rising GP practice workload has outstripped more modest growth in staffing over the past few years. The GP workforce

FIVE FACTS FROM THE GMC'S ANNUAL TRAINING SURVEY

The General Medical Council has published the results of its latest annual survey of medical education and training across the UK.

1 INTENSITY

Of the 53 835 junior doctors who responded to the survey, 43% rate the intensity of their work as heavy or very heavy, up by 2 percentage points from 2015. Just over half (53%) described it as about right, a decrease of 1% since 2015.

2 SUPPORT

The general training environment was described as supportive by 89% of respondents, and 85% rated the quality of clinical supervision in their post as good or excellent.

3 REST

Among trainees in England, 25% said that on a daily basis their working pattern left them feeling short of sleep when at work, and 60% said that they worked beyond their rostered hours daily or weekly.

4 TRAINERS

Half (47%) of the trainers who responded agreed or strongly agreed that they were always able to use the time allocated to them in their role as an educator specifically for that purpose. More than a third (36%) disagreed or strongly disagreed.

rose by 4.75% and the practice nurse workforce by 2.85% between 2010-11 and 2014-15.

However, the report said that GP workload increased “hugely both in volume and complexity” over the period. It noted that additional GPs or more GP hours were only part of the answer to problems with recruitment, retention, and distribution, and further thought should be given to achieving a more equitable distribution of current GP services.

The authors wrote, “There is a need for a broader and more comprehensive policy focus, where the real driver is improved access to primary care and productivity, and where the staffing element of the ‘solution’ takes account of the need to enable effective team-working.”

Workforce data also showed that the UK has one of the highest levels of reliance on internationally trained health professionals of any country represented in the Organisation for Economic Co-operation and Development. About one in three doctors and one in eight nurses in the UK were trained in another country, figures from 2013 have shown.

The report said that a more integrated, nationally led approach was needed, focused on achieving overall healthcare workforce sustainability. “Domestic” policies, including adapting the current workforce and improving regional recruitment, retention, distribution, and productivity, “must be aligned with policies aimed at making any international recruitment efficient,” the report noted.

Matthew Limb, BMJ Careers

5 STAFFING LEVELS

Over two thirds of trainers (69%) agreed or strongly agreed that their trust or board had enough staff to ensure that patients were always treated by someone with an appropriate level of clinical experience. But 14% disagreed or strongly disagreed.

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NHS needs culture shift regarding sleeping at work

The NHS needs a sizeable culture shift in its attitude to doctors sleeping during night shifts, Michael Farquhar, a paediatric consultant sleep specialist, has told *BMJ* Careers.

Farquhar said, “There is still this idea that if you are being paid you must not sleep, and that is fundamentally wrong. Your brain is not meant to be awake at night.”

He continued, “Planning sleep and using sleep in a careful and controlled way to improve the level of care that you are delivering is really important. But there is this blanket cultural idea that we don’t pay people to sleep and it’s wrong. It needs a huge cultural shift.”

Farquhar has held a short session on sleep physiology for trainee paediatricians, which has been included in the London School of Paediatrics’ annual induction for new paediatricians.

One of his recommendations has been that during statutory breaks night shift workers should be encouraged to have short naps of less than 30 minutes.

However, after carrying out an online survey of trainee paediatricians in London, Farquhar found that not all junior doctors were able to achieve such naps.

He received 104 replies to the survey from trainees of all grades from every major London hospital. Only 16% of respondents said that naps during night shift breaks were supported, and 31% said that they were actively discouraged.

Farquhar said that only 10% of respondents were aware of a formal local policy relating to naps on night shift and none were aware of a formal policy on the issue at their hospital. Almost 80% of respondents said that they had received no teaching regarding sleep during night shift working.

Farquhar said that all trainees should be taught about the importance of taking a break during night shifts because it would improve patient safety.

“We can’t stop people working night shifts,” he said. “We clearly need to work night shifts to be able to deliver care. But there are lots of simple things that we can do to try to lessen the impact [on trainees]. Some of that relates to what people do before they come on to night shift. It also relates to what they do during the night shift and what they do after the night shift to recover.”

He said that there was evidence, supported by the Royal College of Physicians and Royal College of Nursing, about the importance of resting during night shifts.

We have to be able to take in that information, assimilate it, understand it and react very quickly,” he said. “If you’re doing that with a brain that fundamentally should be asleep, you’re not going to do it as well as you should do, and that has an impact.”

Abi Rimmer, *BMJ* Careers
arimmer@bmj.com



There is still this idea that if you are being paid you must not sleep, and that is fundamentally wrong



Jenny Higham has been principal of St George's, University of London since November 2015. A would-be surgeon who was alienated by sexism in the operating theatre, she found her "tribe" in gynaecology, where being a woman was an advantage, not an excuse for banter. She spent 18 years at Imperial College's Faculty of Medicine, latterly as vice dean for institutional affairs and director of education. She was a prime mover in the creation of the Lee Kong Chian School of Medicine in Singapore, which opened in 2013, and is chair elect of the Medical Schools Council.

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Jenny Higham Fearing Brexit damage

What was your earliest ambition?

Although not my earliest thought, one intense desire as a provincially based teenager was to escape to London.

What was the worst mistake in your career?

I'll never forget a woman's agonised howl of pain when I told her that her precious IVF baby, conceived after years of infertility, was dead. Two days previously she had described a premonition that her baby would die and requested delivery at 33 weeks. I declined her request. We met again as she was regaining consciousness after a massive abruption. My decision had been obstetrically correct, but the guilt has never left me.

What was your best career move?

Moving into academia but retaining clinical practice (albeit in ever diminishing proportions). The opportunities for reinvention and progression are fantastic.

Who is the person you would most like to thank, and why?

In recent times, Anthony Newman Taylor [of the Brompton Hospital and Imperial College, London] for his brilliantly candid advice, encouragement, and challenge to any complacency of thought.

Where are you happiest?

When I'm enjoying good food, surrounded by my fabulous, noisy, slightly shambolic family—hubby, kids, their partners, and any others who may be free. For perfection, the venue should allow animals so that my daft dog can be there too.

Do you support doctor assisted suicide?

Yes.

What single unheralded change has made the most difference in your field?

I hope I'm wrong, but I fear that Brexit and the accompanying shameful explosion of open racism will cause sustained damage to our reputation among our international staff and students, on whom we rely.

What is your guiltiest pleasure?

Art galleries give me phenomenal pleasure, but I'm not sure that I should feel guilty about it!

What television programmes do you like?

The news: I'm a complete news junkie.

What is your most treasured possession?

My network of fantastic friends.

What, if anything, are you doing to reduce your carbon footprint?

With the move to St George's [in Tooting, south London], I've given up the battle with London driving and now enjoy the delights of the Northern Line.

Where does alcohol fit into your life?

I enjoy it, but I'm tragically cheap to run.

What would be on the menu for your last supper?

If it were my last meal it would be the company rather than the calories that interested me. I also think that I'd be feeling pretty sick.

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