this week

VAPING page 381 • **CONSULTANT PENSION** page 382 • **DIABULIMIA** page 384

EMILE HOLBA FOR THE NUFFIELD TRUST

Anti-vaxxers blamed for measles rise

NHS England's chief executive Simon Stevens has hit out at online anti-vaccination material, warning that telling parents not to vaccinate their children was as bad as telling them not to look when they crossed the road.

Speaking at the Nuffield Trust health policy summit on 1 March, Stevens said, "Across the world two to three million lives are saved each year by vaccination but as part of the fake news movement the vaccination deniers are getting some traction.

"Last year, for example, we saw triple the number of measles cases across England than we had seen the year before, despite the fact that clearly vaccination works."

Stevens said that over the past five years there had been a steady decline in vaccination uptake which meant the government had to continue to win over the public on what he described as "very effective and important health interventions." He said, "We are not being helped on this front by the fact that although nine in 10 parents say they support vaccination, half of them also say that they have seen fake messages around vaccination on social media," he said.

Stevens's comments follow warnings from Unicef that the number of measles cases around the world jumped by 48.4% last year and is still climbing. It blamed the rise on inadequate vaccine coverage caused partly by misinformation.

Stevens said that telling parents not to vaccinate their children was as irresponsible as saying to them, "Don't bother, when taking your kids to primary school, looking which way they cross the road."

Stevens then went on to read out a message from a Whatsapp group for parents at his own daughter's primary school which said, "My kids aren't vulnerable and I think loading up on vaccines blocks their systems from fighting disease as it should do."

He said that the government had a responsibility to explain to parents that vaccines not only benefit their own children but other children as well through herd immunity.

"The fact that the measles, mumps, and rubella vaccine uptake for five year olds is 87.5%, against the 95% that it should be, is a real problem," he said.

Abi Rimmer, *The BMJ*

Cite this as: *BMJ* 2019;364:l1000

Simon Stevens (right), with Mark Dayan of the Nuffield Trust, told the summit that parents not vaccinating their children was as irresponsible as not watching them cross the road

LATEST ONLINE

- Retired paediatrician can remove his name from medical register against GMC wishes
- Government's failure to protect social care is "a national disgrace," say healthcare leaders
- MSF suspends Congo Ebola effort after deadly clinic attacks

SEVEN DAYS IN

No deal Brexit: pharmacists substituting doctors' prescriptions may be unlawful


MARK THOMAS/SPL

A legal challenge to emergency "no deal Brexit" rules that would allow pharmacists to substitute doctors' prescriptions in cases of drug shortages has been launched.

A regulation that came into force last month allows the health secretary, Matt Hancock, to issue "serious shortage protocols" when necessary. The move is part of preparations for the possibility that parliament does not agree a deal for leaving the EU.

The Good Law Project, the non-profit group that has launched the challenge is to argue in the High Court that Hancock had no power to make the regulation. But even if he did, it maintains, the process was so rushed and inadequate as to make it unlawful.

A protocol, if issued, would allow pharmacists to supply a different strength, quality, or pharmaceutical form of a prescription-only medicine or to supply a different medicine. In its written grounds for the claim the group says the move could have "severe adverse consequences for the health, welfare and even the lives of certain vulnerable patients."

The Academy of Medical Royal Colleges said, "It does seem unacceptable that an issue of this importance is not the subject of wide consultation and that medical royal colleges as doctors' professional bodies were not specifically engaged in the process."

Clare Dyer, *The BMJ* **Cite this as:** *BMJ* 2019;364:l919

Drug pricing

Generics colluded to keep price high, says watchdog

The Competition and Markets Authority accused two UK generic drug companies of entering into an anti-competitive "pay for delay" agreement that may have cost the NHS an extra £2m a year. The CMA alleges that the manufacturer Auden Mckenzie paid its rival Waymade to stay out of the market for 20 mg hydrocortisone pills for four years, leaving Auden as the sole supplier. From 2011 to 2015 the cost of a pack of 30 pills rose from £46 to £90, and NHS spending on hydrocortisone rose from £1.7m to £3.7m a year, the CMA said.

Legal news

Ex-director of NHS England pleads guilty to voyeurism

Jonathan Fielden, former deputy medical director of NHS England, pleaded guilty at Luton Crown Court to one count of voyeurism. Fielden, 55, who was also the NHS's director of specialised commissioning services, admitted spying on a person taking a shower, through a hole in the loft of a private home. The admission relates to a single event that took place between 2014 and 2016 at a property in Linslade, near Leighton Buzzard. Police said that the offence was not related to his professional practice as a doctor.

War zones

Royal colleges and BMA urge ministers to lobby UN

Fifteen medical royal colleges and the BMA wrote to the UK foreign secretary, Jeremy Hunt, asking the government to lobby other UN member states to tackle the issue of attacks on medical facilities in conflict zones. Their letter urged UN member states to enforce Security Council Resolution 2286, which demands that warring parties comply with the 1949 Geneva Conventions that criminalise targeted attacks on medical workers and facilities. The Royal College of Emergency Medicine said that 388 attacks on medical workers and hospitals occurred in war zones in 16 countries in 2018.

Violence against doctors in Sudan condemned

The Sudan Doctors Union UK branch and the Sudanese Doctors Union of Ireland condemned attacks on doctors after Sudan's president, Omar al-Bashir (right), declared a state of emergency on 23 February. Masked security men stormed into residences in Khartoum, searching, beating, and arresting doctors. Doctors were also attacked in their clinics, hospitals vandalised, and patients terrorised, they said, and tear gas was fired into a lecture room at the University of Science and Technology to force out students, who were then beaten.

Northern Ireland

Waiting lists for hospital treatment rise 43%

The number of people waiting longer than a year for inpatient treatment in Northern Ireland has increased by 43% in 12 months, showed figures from Northern Ireland's Department of Health. From October to December 2018 some 21 477 patients waited more than a year for inpatient treatment, up from 14 979 in the same period of 2017. By comparison, 2237 patients in England waited more than a year for hospital treatment in 2018, said the Royal College of Surgeons.

Cervical cancer

New national screening campaign is launched

Public Health England launched a new campaign to increase the number of women attending cervical screening (left). The campaign, which includes a TV advertisement, has been launched in response to falling numbers being screened. It will encourage women to respond to invitation letters and to book an appointment at their GP practice if they have missed a screening. It will also provide advice on how to make the test more comfortable.

Planetary health

WONCA urges family doctors to commit to action

The World Organisation of Family Doctors issued a declaration urging the world's family doctors to commit to acting on planetary health. Steps could include advising patients on their choice of food and energy sources, using active transport, it said, as well as understanding "the environmental footprint of health services, including energy and waste services, production of pharmaceuticals, over-prescribing, and over-treatment."

MEDICINE

Sanitary products will be available for free in all NHS England hospitals from July

Sanitary products

Free supplies for patients are a "big step forward"

The BMA welcomed a move by NHS England to make sanitary pads and tampons freely available from July for all patients who need them. The issue was first raised by doctors at the annual BMA conference last June, since when the association has been campaigning for free patient access. A recent BMA investigation highlighted the often poor and inconsistent provision of sanitary products in hospitals, which it said has a damaging effect on patients' health, dignity, and wellbeing.

Bipolar disorder

Most Scottish patients get suboptimal treatment

A quarter of patients with bipolar disorder in Scotland are treated with antidepressant monotherapy and do not receive lithium as recommended by NICE, a national data linkage study showed. "Our findings suggest that most patients with bipolar disorder in Scotland are receiving treatments such as antidepressant monotherapy that are at best ineffective and, at worst, detrimental for long term outcome," warned the study authors, led by Daniel Smith, professor of psychiatry at the University of Glasgow.

Organ donation

Opt-out system could "save 700 lives a year"

England will have an opt-out system for organ donation (above) from spring 2020, after a bill to implement the change passed its final stage in parliament. When the law comes into force all people in England will be presumed to consent to donating their organs unless they register to opt out. The government believes the change in the law could save 700 lives a year. An opt-out system was introduced in Wales in 2015, and Scotland has approved the principles of a similar scheme (see Head to Head, p 392).

Campaign for more child organ donors is launched

NHS Blood and Transplant launched a paediatric and neonatal organ donation strategy to increase organs available. It said that 177 children in the UK are waiting for an organ transplant and that 17 children died in 2017-18 while waiting for a donor. Child donors have remained static in recent years, at 57 last year and 55 in 2013-15, while the number of adult organ donors has risen.

Robotic surgery

Evidence for cancer surgeries is "lacking"

The US Food and Drug Administration warned that the use of robotically assisted devices for cancer surgeries is not supported by research. A study published last November in the *New England Journal of Medicine* found that robotically assisted radical hysterectomy in women with cervical cancer was associated with lower overall survival than traditional surgery.

Cite this as: *BMJ* 2019;364:l1011

CANCER SCREEN

An estimated 83% of cervical cancer cases could be prevented if all eligible women attended screening regularly

(Public Health England)

SIXTY SECONDS ON… VAPING

IS TEENAGE VAPING A WORRY?

The trend in those vaping is up but the numbers are still low. Public Health England (PHE) says in a report that only 1.7% of under 18s use e-cigarettes weekly or more, most of whom also smoke. Among those who have never smoked, only one in 500 uses e-cigarettes regularly.

BUT HEADLINES SAY THE NUMBER OF USERS HAS DOUBLED?

It has, if you go back as far as 2014. Surveys by Action on Smoking and Health (ASH) also show no increase at all between 2017 and 2018. These surveys suggest that 3.4% of 11 to 18 year olds vape, half of them at least once a month and half weekly or more.

SO IS THIS WORRYING, OR NOT?

Depends where you stand. Martin McKee of the London School of Hygiene and Tropical Medicine is concerned, Deborah Arnott of ASH said the trend needs watching, while John Newton of PHE was pleased that the UK hasn't seen the same rocketing levels of teenage e-cigarette use as the US.

SO, WE'VE NOT BEEN SUCKED INTO FOLLOWING AMERICAN TEENS?

Not as yet. This may be explained by the absence of a "cool" e-cigarette in the UK. In the US a 78% year-on-year rise in vaping among teenagers has been blamed largely on Juul, a product designed to appeal to teens. Juul only recently became available in the UK.

AVAILABLE WHERE?

Sainsbury's has signed a deal to sell it in its 1400 stores, to the disgust of Simon Capewell, a public health specialist at Liverpool University. Sainsbury's said it was offering customers "choice, quality, and value," while Juul said, "No young person should ever try our product."

MANY IN THE US HAVE, THOUGH?

So it seems. Scott Gottlieb, commissioner of the Food and Drug Administration, has questioned Juul's commitment to discouraging teens and said his agency may restrict access to products if the "exploding epidemic" of teenage vaping continues, even at the expense of denying smokers opportunities to quit.

SO WILL JUUL PROVE COOL HERE?

That's certainly a worry.

Nigel Hawkes, London

Cite this as: *BMJ* 2019;364:l979

CONSULTANTS' CONFERENCE

"End punitive cuts to pension tax relief or lose more doctors"


SARAH TURTON/BMA

The changes to pension regulations that are imposing "excessive rates of taxation" on hospital doctors and exacerbating the medical workforce crisis must be reversed, consultants have warned.

The BMA has warned that changes to rules on pension allowance introduced in 2016 have landed consultants with huge unexpected tax bills and deepened the retention crisis in the profession.

Some 60% of the 4000 consultants in England who responded to a recent BMA survey said that they were considering early retirement, and many cited the penalties incurred by breaching annual and lifetime pension allowance limits as a key reason.

Vote to lobby HMRC

A motion passed by the BMA consultants conference on 27 February demanded that the body lobby HMRC, the Department of Health and Social Care, and the Treasury (and the respective departments within the devolved nations) "to alter the annual allowance calculation so that high earning public sector workers are not subjected to excessive rates of taxation."

The conference noted that a significant number of consultants are now subject to both the lifetime and complex annual allowance tax charges and calculations, which were having a "damaging effect" on retention, as many doctors were no longer taking on additional work because of the "punitive effective rates of taxation."

In addition, the motion called on all NHS employers to pay the employers' pension contributions to employees who have opted out of the NHS pension scheme as part of the "total reward package."

It also demanded that the BMA note the successful legal action by judges and firefighters against damaging changes to their pensions and that it "fully support, including with any external legal or analytical support required, the consultants committee in mounting such legal action as is determined by the consultants committee to be necessary against deleterious changes to consultants' pensions."

Routine statements

A separate strand of the motion called on the NHS Business Authority to routinely issue pension statements relating to

People who have taken on additional roles and done additional work have paid to go to work Tony Goldstone, consultant radiologist

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BMA urged to leave "spineless" pay review body negotiations

Hospital consultants have demanded a formal withdrawal from pay talks with the Review Body on Doctors and Dentists Remuneration (DDRB) in protest at a decade of falling income.

The BMA has already given evidence to the review body for 2019-20 and has called for a review of the process after some consultants received a "derisory" below inflation pay rise last year, despite the scrapping of the 1% pay cap for NHS staff.

More stringent action

But Kevin O'Kane from the BMA's regional consultants committee for south London, who proposed the withdrawal motion, argued that more stringent action was necessary, noting that the BMA's submission to the DDRB showed that consultants' salaries have fallen by up to 30% in real terms over the past 10 years.


The time for a repetitive collective impression of Oliver Twist is over Kevin O'Kane

"The time for a repetitive collective impression of Oliver Twist is over," said O'Kane. "I can see absolutely no point in continuing with this charade. The DDRB is spineless because it will not recommend the type of package that consultants deserve, and it's toothless because, even if it were to do so, it would be ignored by the government.

"This is not an independent pay review body, it's a government sponsored, government appointed pay control body."

Keith Brent, the former chair of the BMA's consultants committee and a south of England committee member, argued that the motion should be taken only as a reference, as the only alternative to the DDRB would be negotiating directly with government, which could be even worse.

Brent said: "Although it was quite frustrating appearing before the DDRB, I actually found it was largely sympathetic to many of our arguments. Indeed some of its reports were quite supportive.

"The problem is not the DDRB, it's government. If we get rid of the DDRB, then we negotiate directly with government. I'm not sure that improves our situation."

Test the alternatives

But the motion was passed, after Andrew Hobart, an emergency medicine consultant based in London, also spoke in favour. He said: "The time has come to pull out of the DDRB and test the alternatives. Can we really do worse than a 0.75% pay rise? I don't think so."

The BMA said that any changes would not occur until 2020.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l1001

Conference delegates passed Andy Thornley's motion

pension growth and potential annual allowance charges annually, so doctors are fully aware of what they owe in tax.

Andy Thornley, consultant cardiologist from the BMA's north east consultants council who proposed the motion, said the measures were exacerbating and already "acute workforce crisis."

"This is something that is going to affect everyone in this room. In some cases it really isn't worth taking on any extra work," he said. "I want the BMA to actively lobby to change the annual allowance calculation. We need to decrease these effective taxation rates on our members so that it continues to be worthwhile doing work in the NHS and additional work. We have a workforce crisis. It is important that pensions' impact on that workforce crisis is dealt with."

National scandal

Tony Goldstone, consultant radiologist from East Yorkshire and BMA pensions expert, said he fully endorsed each part of the motion.

"I have helped probably in excess of 100 consultants who have had marginal rates in excess of 100%," he said. "That means that people who have taken on additional roles and done additional work have paid to go to work.

"This is a national scandal that is already compromising patient care. If it's not reversed, it really could be the end of the NHS as we know it."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l977

FEATURE, p 390

Two fifths of GPs want to quit by 2024

Four in 10 GPs intend to quit in the next five years amid growing workload pressures, a survey has suggested.

A Warwick Medical School survey asked all 1697 GPs in the Wessex region how workload pressures were affecting their career intentions, receiving 929 responses (a 55% response rate). The results, published in *BMJ Open*, reveal that 42% (361) of GPs intend to leave or retire from NHS general practice within the next five years. This compared with 32% (439) of those surveyed in the same region in 2014, an increase of almost a third.

Some 59% of GPs reported a fall in morale over the past two years, and almost half (49%) said they had brought forward their plans to leave general practice. Respondents cited workload as the most significant problem, with 51% reporting that they are working longer hours than in 2014.

Lead author Jeremy Dale said, "Morale and job satisfaction has been deteriorating for years, and we have known this is leading to GPs leaving the profession early. Turning this around will be a mammoth task."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2019;364:l960

"Lansley's monster" to be retired under plans to repeal competition rules

NHS England has outlined plans to repeal divisive laws on competition and procurement that were introduced in the Health and Social Care Act 2012.

The move, which was trailed in the NHS long term plan, is designed to free commissioners tendering service contracts on the open market and to improve service integration. If approved, the law change, recommended by the Commons health and social care select committee, would mark a major shift away from the agenda championed by former health secretary Andrew Lansley, the architect of the 2012 act.

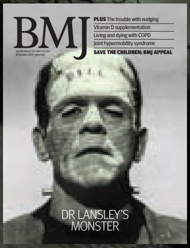
In a consultation document setting out its proposals, NHS England said the current rules were at odds with efforts to develop greater collaboration and that "targeted amendments" to primary legislation would free the NHS from "overly rigid" procurement requirements.

Existing rules should be scrapped and replaced by a "best value" test, which would give commissioners the freedom to decide which circumstances would be appropriate to use procurement and competitive tendering. The test would account for factors such as the impact on quality of care and health outcomes.

NHS England chief executive, Simon Stevens, said, "In developing the long term plan we heard from lots of people that progress would be accelerated towards a better integrated health service if some targeted changes could be made to the law. These proposals are based on those initial conversations with local NHS leaders and senior clinicians. We are now seeking a wider range of views before making our final recommendations to parliament."

The consultation will run until 25 April.

Gareth Iacobucci, The BMJ **Cite this as:** *BMJ* 2019;364:l990



OTHER PROPOSED CHANGES

- Merging NHS England and NHS Improvement
- Removing the Competition and Markets Authority's powers to review foundation trust mergers
- Giving NHS Improvement targeted powers to direct mergers or acquisitions involving NHS foundation trusts
- Giving clinical commissioning groups and trusts the power to create joint decision-making committees
- A shared duty for CCGs and trusts to promote a "triple aim" of better health, better care, and efficient use of resources
- Giving the health secretary powers to set up integrated care trusts in cases where local commissioners wish to bring services together under a single contract
- Giving NHS Improvement powers to set annual capital spending limits for foundation trusts

UK remains in middle of European health table

The UK has been ranked 16th in a wide ranging assessment of 35 national health systems in Europe, just below Portugal (13th), the Czech Republic (14th), and Estonia (15th).

The rankings were published in the 2018 survey by the Euro Health Consumer Index (EHCI), which has been producing annual assessments of the performance of national healthcare systems in Europe since 2005.

The results were based on 46 indicators grouped under six headings: patient rights and information, access to medical care, treatment outcomes, range and reach of services, prevention, and use of pharmaceuticals.

Arne Bjornberg, chair of the Health Consumer Powerhouse, which produces the index, said European healthcare was steadily improving. “Infant mortality and survival rates of heart disease, stroke, and cancer are all moving in the right direction. Patient choice and involvement are developing,” he said.

Johan Hjertqvist, HCP’s founder, said the overall advances being made in medical science and treatment were hamstrung by lack of progress on healthcare reform. He pointed out that most people cannot move across borders for treatment despite EU legislation making this possible and that a third of Europeans live in countries with poor access to care.

1 TOP SPOT Switzerland topped the table, followed by the Netherlands and then Norway, while in last place was Albania, preceded by Romania and Hungary.

2 ACCESS The UK, which ranked 15th in 2017 and 14th in 2016, scored particularly poorly this time on accessibility, whether this be a same day visit to a GP, direct access to a specialist, or waiting times for major surgery. Only Ireland performed worse in this category.

3 PREVENTION The UK was ranked in second place alongside the Netherlands and just behind Norway in its use of preventive policies, especially infant and HPV vaccination, physical activity measures, and smoking prevention. It also scored well on patients’ rights and Information.

4 TOP-DOWN The survey acknowledged that “mediocre outcomes of the British healthcare system have been improving.” But the report said further improvements in performance were being hindered by “an autocratic top-down management culture.”

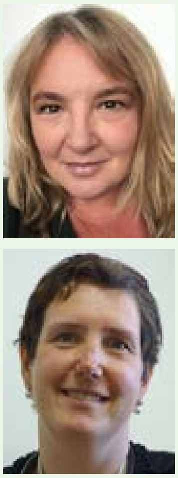
5 PSYCHIATRIC CARE Netherlands failed to secure the top spot in the rankings for the first time in a decade, coming second behind Switzerland. The change was partly due to the use of two new indicators—access to psychiatric care for children and suicide reduction. The Netherlands is one of a handful of countries where numbers of suicides have risen.

Rory Watson, Brussels Cite this as: *BMJ* 2019;364:l971

NEWS ANALYSIS

Diabulimia: the most dangerous eating disorder

Diabetologists and mental health professionals work together to change dangerous behaviours



Dasha Nicholls (top), from the RCP, and Helen Partridge, consultant at Royal Bournmouth Hospital

Diabetes and mental health teams on the south coast of England and in London have joined forces to tackle what the media call “diabulimia,” also described as “the world’s most dangerous eating disorder.”

Diabulimia is an eating disorder in which patients with type I diabetes restrict insulin to lose weight. This can lead to early onset of serious complications such as blindness and amputations. It is most common in young people aged between 15 and 30, particularly women, and involves a complex interaction of factors—such as insulin, blood glucose, emotions, and body image—that cross diabetes and mental health care.

Food, weight, and body image

Dasha Nicholls, chair of the Royal College of Psychiatrists’ eating disorders faculty, said: “Because diabetes forces you to focus on what you eat, it’s not unusual for that to get tangled up with feelings about food, weight, and body image. That can become dangerous very quickly.”

Patients make a link between insulin and weight gain right from diagnosis, explained

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Locum is suspended for a year for faking coronary clerking

A doctor has been suspended from the UK medical register for 12 months after a tribunal found he failed to attend a patient after a stenting procedure, then dishonestly wrote in her medical notes as if he had examined her.

Attila Czipp, who previously practised in cardiology in his native Hungary, was working as a locum senior house officer in acute medicine at the Royal Cornwall Hospital when a 72 year old patient who had just undergone coronary artery stenting after a heart attack arrived in the coronary care unit. Around midnight, Czipp was given the routine task of “clerking” the patient, an admission process involving the taking of a history, a physical examination, prescribing of drugs, and recording findings.

A specialist ward nurse persuaded the patient to stay

SPL

Helen Partridge, consultant and clinical lead for diabetes and endocrinology at the Royal Bournemouth Hospital; profound weight loss is often an indicator of type 1 diabetes and when patients start taking insulin they put weight back on. Around one in five women and two in five men with type 1 diabetes are believed to omit insulin at some point to try to lose weight. The south coast pilot will aim to identify patients at risk so that a multidisciplinary team can provide early psychological support.

Patients with type 1 diabetes put weight on when they start taking insulin

These are frail patients who are likely to present repeatedly at emergency departments with acute ketoacidosis, Partridge said.

The pilot will send a rapid response team into emergency departments and educate primary care staff to consider if there are reasons a patient may be struggling to control their diabetes.

Slow changes

Reasons can be explored by the multidisciplinary team at joint clinics and through phone support. Patients will be encouraged to make slow changes to bring their blood sugar down, perhaps increasing insulin by just one unit a week.

“As diabetologists we have no idea how to manage eating disorders and the eating disorders team have no idea how to manage diabetes, so it’s very much a multidisciplinary thing. You can’t treat one without the other,” Partridge said. Even ways of working are different, with diabetologists allowing patients to take ownership, whereas the eating disorders team take control, she added, so it’s important to integrate the two approaches according to what the patient needs at that time.

Where required, patients can be referred to a variety of eating disorder workshops attended by members of the diabetes team, or even admitted as inpatients.

The second pilot, run by King’s Health Partners in London, which has been providing specialist support to patients with diabulimia for some years, will attempt to demonstrate the effectiveness of an integrated approach in a cohort of 40 patients with severe symptoms.

If the two pilots, funded by NHS England, prove successful, the multidisciplinary approach will be rolled out across England. Jonathan Valabhji, NHS England’s national clinical director for diabetes and obesity, said: “With further evidence from these pilots and more joined up working, we will treat many more patients in the near future.”

Type 2 diabetes

Tony Winston, a consultant in eating disorders who set up the UK’s first specialist service for patients with diabetes in Warwick in 2011, welcomed the pilots but pointed out that patients with the much more common type 2 diabetes had a similar prevalence of eating disorders.

“There has been almost no attention given to type 2 diabetics who are also a neglected group,” he said. “With type 1, the most reliable data we have is for young women which suggests that about 10% of them will have an eating disorder versus around 4% in the general population—so it is more than double. In type 2, some figures suggest as many as 10% may have an eating disorder, but it’s rarely recognised.”

Ingrid Torjesen, *The BMJ*

Cite this as: *BMJ* 2019;364:l982

TO LOSE WEIGHT it is believed 40% of young men with type 1 diabetes omit insulin at some point

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awake until the doctor had examined her. Later Czipp handed in the patient’s completed clerking form, and left the unit. After establishing that the patient had not seen a doctor, the nurse carried out the examination herself, found the patient to be stable, and raised the matter with superiors later.

Czipp was called in to see the trust’s medical director and conceded that the information on the form was false. His employment was terminated and the GMC was informed.

Czipp did not attend his medical practitioners’ tribunal hearing in Manchester. In a letter to the GMC he sought to retract earlier admissions, suggesting he had relied on poor legal advice. He contended he had completed the form intending to see the patient but, on finding her asleep and being bleeped to see another patient, had decided to put off the examination and return later.

Czipp copied the patient’s history from her medical notes without explaining it was not obtained by his examination

But, said Nathan Moxon, the hearing’s chair, Czipp had copied the patient’s history from her medical notes without a note to explain it was not obtained by his own examination. This risked potentially endangered the patient, he said, although in the event there was no patient harm.

The GMC asked the tribunal to strike Czipp off, arguing that both clinical misconduct and lack of probity were proven, and that he could not remediate failings he did not admit.

But, Moxon said, “The tribunal took into account that this was a single incident that took place on a single night and with regard to a single patient who was not harmed, although there was potential for harm.”

Before working again Czipp will have to show a review hearing he has tackled his failings.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2019;364:l978

NIKLAS HALLE'N/AFP/GETTY IMAGES

THE BIG PICTURE

Have suitcase, will protest

Last week 28 women dragged suitcases across London’s Westminster Bridge to demand the decriminalistion of abortion in Northern Ireland.

The marchers, led here by actress Nicola Coughlan, star of Channel 4’s *Derry Girls*, represented the number of women who are forced to travel to England every week to undergo a termination. The procedure is outlawed in Northern Ireland unless the woman’s life is at risk or if there is a risk of permanent damage to her physical or mental health.

“Women are being treated like criminals in their own country. I’ve had friends who have had to make this journey, it feels very personal,” Coughlan said after the march.

The campaign, organised by Amnesty UK, calls on the UK government to intervene and change the law in Northern Ireland in the absence of ministers at Stormont. And it follows the change in Irish law last year.

The suitcases contained the names of the 62 000 signatories to a petition that was delivered to Karen Bradley, the Northern Ireland secretary.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2019;364:l999

EDITORIAL

Modern slavery: a global public health concern

Health professionals are well placed to identify and advocate for victims

Modern slavery is a global public health concern,[1] yet health professionals are often unaware of what it is, what it looks like, who it affects, and what, if anything, they can do about it.[2]

There were more than 40 million victims worldwide in 2016, with every region affected.[3] It is a largely hidden crime, but one hidden in plain sight. It thrives on human vulnerability, such as where there is poverty or people escaping war. It is evident in our local communities in places such as car washes, beauty salons, farms, and factories.[4]

Modern slavery—which is often called and is inclusive of human trafficking—is an umbrella term that includes the recruitment, movement, harbouring, or receiving of children, women, or men through the use of force, coercion, abuse of vulnerability, deception, or other means for the purposes of exploitation.[5] It includes holding a person in a position of slavery, servitude, or forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after.[6] It includes sex trafficking, forced labour, forced criminality, domestic servitude, and forced marriage.[4]

Complex comorbidities

Modern slavery is a gross manifestation of social and economic inequality that violates basic rights, including a right to health.[7] Complex comorbidities are characteristic of this population; survivors are at high risk of physical injury, exposure to infectious diseases, suicide, restricted access to healthcare, and serious mental health problems.[8,9]

While modern slavery has been considered mainly a law enforcement matter, clinicians should also be concerned because many victims seek healthcare at some point during their exploitation.[10,11] Healthcare professionals also occupy a trusted, privileged position with unrivalled access to vulnerable populations[11]; these advantages can be mobilised to protect exploited patients and prevent harm. Healthcare is therefore at the frontline of identification, and of ensuring victims access their rights to health, security, and liberty.

Healthcare is at the frontline of identification, and of ensuring victims access their rights

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Elizabeth Walton, clinical lecturer, University of Sheffield

Toby Bonvoisin, academic f1 doctor, Hull and East Yorkshire Hospitals NHS Trust

Hanni Stoklosa, instructor in emergency medicine, Brigham and Women's Hospital, Harvard Medical School

To provide care for this population, clinicians need to know what to look for and how to act and optimise outcomes.[2] There are several "red flags" that practitioners should look out for: victims may be nervous, might not speak for themselves, or may appear to be under the control of others; companions might translate for or talk over them; victims may have old or untreated injuries, may be submissive and afraid, could be unregistered with health services, or have moved frequently within or between countries.[10,12]

In response, clinicians should try to talk to patients suspected of exploitation alone, and arrange professional interpreters where needed. They should be reassuring, highlighting that it is safe to speak, and should take time to build rapport. Furthermore, they should recognise that victims are likely to be traumatised so should ask non-judgmental and sensitive questions and give the patient time to talk about their experiences if they wish to.

If slavery is suspected, helplines are available in most countries to connect with specialist support including safe accommodation; the Global Modern Slavery Directory has a comprehensive list.[13] Law enforcement matters need to be considered carefully. Victims may not want to engage with the police for fear of reprisals or deportation. Healthcare professionals should seek advice from national helplines, their colleagues, and local guidelines, and work with the patient to make informed decisions about involving authorities.[14]

Awareness

The development and testing of training, guidance materials, and practice protocols are in their infancy and there is an urgent need to improve practitioner awareness, skills, and processes.[15] Awareness materials are growing quickly and focus on "spotting the signs" but validated tools to assist patient screening are limited. The HEAL Trafficking toolkit[16] and the Adult Human Trafficking Screening Tool and Guide[17] use a best practice approach.

Clinicians need knowledge of, and confidence in, victim referral systems. The UK national system, for example, has encountered many problems, including inadequate inspection of care facilities.[18] Finally, practitioners can be important contributors to an emerging public health approach to tackling modern slavery that promotes a preventive agenda.[19]

Clinicians are uniquely placed to help people affected by this crime, through the patients they see, the power of their voice, and the opportunities they have to advocate for broader preventive measures.

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EDITORIAL

Should palliative care be rebranded?

Changing perceptions is more important than changing names

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Nearly 30 years after the World Health Organization first defined "palliative care," we are no closer to agreeing what the term means.

Palliative care has driven major improvements in the care of people with life limiting illnesses and fostered more open public discourse about death and dying. National and international policies advocate better access to palliative care for everyone who needs it.

By 2002, WHO had a new definition, which is still in use: "Palliative care is for people with life threatening illness; prevents and relieves suffering through holistic care; and is applicable from early in the illness."[4] The central tenet has always been a focus on what matters to the patient and those close to them, captured by the term "quality of life." The emphasis is on personal, values based care instead of disease centred concepts of illness and treatment. The lived experiences of health related suffering are afforded greater significance.[5]

UK guidance uses the term "palliative and end-of-life care" more specifically for people in the last year of life, even though prognostic judgments are problematic.[6] The intention is to show that palliative care is relevant well before the final weeks of life. Paradoxically, however, combining these terms links palliative care inextricably with imminent death and dying in the minds of professionals and the public.

Studies report negative views about receiving palliative care among patients and families, particularly those with no direct experience of these services.[7 8] The Royal College of Physicians emphasises the importance of talking about dying to help tackle professional discomfort about introducing palliative care.[3 9]

Negative perceptions

Could a change of name change these negative perceptions? One paradigm refers to "early" or "integrated" palliative care to emphasise it can begin at diagnosis. Palliative care is even being rebranded to make it appear more socially acceptable. "Enhanced supportive care," for example, delivers specialist palliative care from within oncology services. It is not clear, however, if this is helpful or confusing for patients and families.[10] "Best supportive care" is another euphemism that can have adverse consequences unless that care is well coordinated, and includes primary and secondary care teams who have easy access to palliative care specialists if needed.[11]

Use of language matters, and getting it right or wrong can promote or prevent an ethos of shared endeavour across multidisciplinary teams. Negative language in the context of palliative care has the potential to cause distress and harm to patients—talk of "treatment withdrawal" or "futile treatment," for example, can make people feel abandoned or devalued. Terms such as "ceiling of treatment" or "ceiling of care" are still used by professionals and in good practice documents to indicate that patients who are not expected to recover fully will not benefit from intensive treatment. This language can give the impression, however, that a person is being denied potentially helpful interventions.[12]

Use of language matters, and getting it right or wrong can promote or prevent an ethos of shared endeavour

Positive communication

Consistent, positive language is better for everyone—in team working, shared decision making, and when offering palliative care. Positive communication means finding out what matters to patients and families, before discussing the benefits, realities, and limitations of all the available options, framed in a way that maintains hope.[13 14]

Good palliative care should be available from early in the course of a final illness, whatever its underlying cause, and many clinicians are acquiring greater expertise. Training opportunities and required curricular competencies go a long way, but it is equally important that healthcare professionals value and invest time in this important aspect of good clinical practice.[15] Palliative care specialists play a key role in providing expertise, education, and support for other teams. They should be introduced to patients and families in a positive way—as an opportunity for specialist advice on managing pain and other symptoms, for help with complex decision making, and in preparing for the future.

As the 2018 Astana Declaration makes clear, palliative care is integral to the goal of universal health coverage. Instead of changing its name, we should work to change attitudes—both professional and public—from at times negative to universally positive.

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PERSONAL FINANCE

Three weeks to find £25 000: the NHS doctors remortgaging to pay pension tax bills

Doctors facing debt because of unexpected HMRC demands are considering cutting their hours and retiring—with potentially serious consequences for services. **Stephen Armstrong** and **Antony R Goldstone** report

Continuing uncertainty over recent pension tax changes may mean senior doctors opting out of the NHS pension scheme, reducing their hours worked, or seeking early retirement, as *The BMJ* reported in January.

These fears compound findings from a freedom of information request by the *Health Service Journal* last year. It discovered that 245 561 staff had opted out of the NHS pension scheme in the past three years: about 16% of the scheme's working members, says the pensions firm Royal London.

Andrea Sproates, head of the independent financial advisers Chase de Vere Medical, told *The BMJ*, "We are encountering increasing numbers of doctors opting out of the NHS pension scheme at all ages. These may be older members who are considering retiring early or reducing NHS or private practice hours, or younger members who are considering leaving because of affordability concerns.

"We have also seen doctors taking out loans or even remortgaging to pay pension tax bills. Many of these doctors have been unable to avoid these bills and in some instances didn't expect them, because the tax liability is often an unknown quantity and so is very difficult to plan for."

A BMA survey published this year found that six in 10 NHS consultants (2446 of 4089 respondents) intended to retire before or at age 60, while over a third (36%) expected to reduce the days they work in the NHS by as much as half—and pension rules were the second biggest reason.

Unexpected £25 000 bill

Since the 31 January deadline for payment of 2017-18 income tax *The BMJ* has spoken to senior NHS doctors and found many similar stories. One intensive care doctor in a major hospital in northern England had an unexpected £25 000 bill last year and had to find the money in three weeks.

"Even doctors who earn well aren't going to have that sort of money available," he told *The BMJ*. "If you get a bill from HMRC for £25 000 your options are that you pay it, or you pay it. You either find or borrow the money.

"I managed to borrow some from my family last year, and the NHS pension scheme has paid my £25 000 on account for me—but, for that, it will take the money off my lifetime allowance [of pension income] and charge me interest until I'm 60. If the hits keep coming I will have to remortgage."

Penalised for success

A full time GP partner in a Yorkshire town in her mid-40s had a pensionable income last year of £161 000. As a GP partner she is self employed and therefore has to pay the employer and employee contributions, totalling £56 000. This year her initial tax bill was estimated at £36 000, but her accountant advised paying £72 000 that month: this comprised a £10 000 emergency payment for possible breaches in previous years; the total that she had breached last year; and an increase in her overall tax prediction.

Doctors are taking out loans or even remortgaging to pay unexpected bills because this tax is very difficult to plan for
Andrea Sproates, Chase de Vere Medical

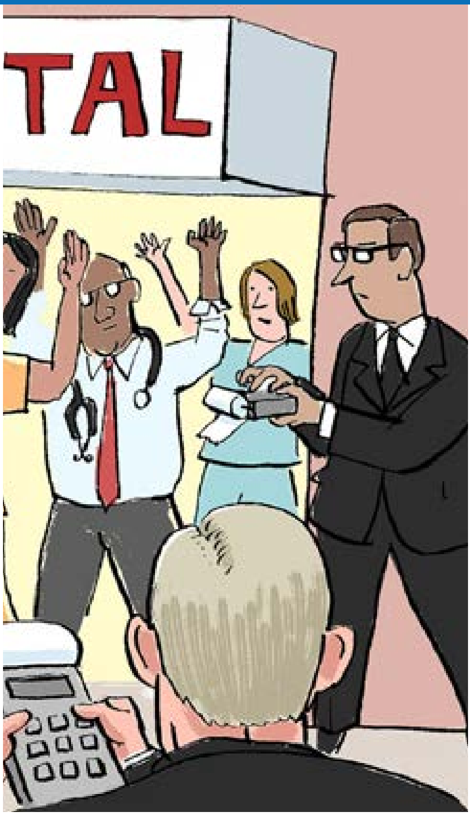
She has a payment on account of £38 000 due in July, meaning that she will pay £110 000 tax in this calendar year.

"I have worked consistently in that successful partnership for 15 years, and one of the key reasons for our success has been our consistent team and full time clinical leads," she explains. "It angers me that I am now being penalised through the pension tax system for delivery of such care.

"I want to continue working full time, and I'm happy to pay my fair tax, but I'm worried about the personal effect that will have. We don't plan to reduce our work commitments, so the chances are that we will withdraw from the NHS pension scheme."

Betrayed by initial promises

Doctors feel betrayed by the promises they were given when starting out. One 48 year old surgeon in Wales recalls, "The deal when we started as junior doctors was: you work like



MALCOLM WILLETT

crazy, have no social life and don't earn that much—but later in life you have the NHS pension.

"I remember a financial adviser coming to us in our first six months and saying, 'Think about endowments or pensions, but do not come out of your NHS pension—it's one of the best there is.' They're basically reneging on that deal."

One oncology consultant in his mid-40s from Yorkshire, who does not do any private practice, was recently promoted to clinical director and saw his pensionable income rise by £10 000 this year to a taxable income of £111 640 in 2017-18.

He had already submitted his tax return, which, together with less than £1000 income from elsewhere, would have resulted in a small tax refund from HMRC after professional subscriptions and so on. When a colleague received an unexpected tax bill the consultant realised that he too could be affected. After speaking with his accountant he has a £40 000 annual allowance bill: that is, he has to pay £40 000 from his taxed income.

Because he has used his "carry forward" he is expecting an annual allowance bill every year until he retires. Next year's bill won't be as huge, but the year after that (because he will have a pay rise from an increment) he will get another five figure bill. For consultants, pay rise years are now something to dread rather than a symbol of reward for their seniority.

Had the clinical director's income been just £1641 lower his annual allowance bill would have been £13 500 smaller

There is another point to consider here. This consultant was only £1640 over the "tax cliff" of the threshold income limit of £110 000. Had his income been just £1641 lower his annual allowance bill would have been £13 500 smaller.

"I'm trying to come to terms with having paid a five figure bill for the past couple of years to be clinical director," he explains. This highlights a major disincentive for clinicians to take on additional roles or paid work (even if non-pensionable) that push them over this "tax cliff."

Having taken professional advice, and not wishing to use the "scheme pays" loan for a role he is unlikely to have until retirement, he has had to remortgage his house to pay the charge.

Pushing for reform

The BMA is pushing for reform of pension taxation, although it has not yet provided details of what it is asking for.

"Taxing anyone on pension scheme growth that they have little or no control over is grossly unfair," says Sproates—"especially as the tax is due now and yet the benefit may not be received for many years."

She warns doctors against leaving the NHS pension scheme without a thorough understanding of what they will gain and lose. It is a rare final or average salary pension that includes death in service benefits and enhanced benefits on the grounds of ill health.

"The first step is to be aware of any potential tax liability and then make an informed decision," she suggests.

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CHANGES TO PENSION TAX RELIEF RULES AFFECT HIGH EARNING DOCTORS

The increased pension pressure is caused by changes to regulations in 2016 that reduce pension tax relief for some higher earners.

You pay tax on any growth of the deemed value of your pension over your tax-free annual allowance of £40 000. The change means that, for every £2 of "adjusted income" over £150 000, your annual allowance is "tapered down" by £1, to a minimum of £10 000.

Your adjusted income is, broadly, your "threshold income" (essentially, taxable income from all sources) plus any deemed pension growth, as stated on your pension savings statement.

In practice, most doctors with a taxable income of £160 000-£170 000 face full tapering of their tax-free allowance if they remain in the NHS pension.

An HMRC spokesperson tells *The BMJ*, "The annual allowance (AA) taper only affects higher earning pension savers. The AA charge helps control the cost of pensions tax relief by claiming back the relief received on contributions made in excess of the AA limit. This ensures that the benefit these individuals receive is not disproportionate to that of other pension savers."

Oversimplification and complications

But this is an oversimplification with potentially huge financial effects, some doctors think. You can "carry forward" unused allowance from the past three years but, generally, once you have used your carry forward it is gone forever, and you can expect an annual allowance charge every year.

One GP partner in Yorkshire explains, "I have been in the NHS pension scheme since I qualified in August 1988. I was aware of the huge decrease to the allowed lifetime allowance and annual allowances since they were introduced in the late 2000s. I always avoided extra tax on the annual allowance, as the option to carry forward any unused allowance protected me.

"When tapering came into effect in 2016-17 I mistakenly felt it wouldn't affect me, as my annual salary was always, and indeed continues to be, lower than the adjusted income cut-off of £150 000—but my pension growth took me over."

The GP's accountant thinks that, for 2017-18 and 2018-19, he is likely to have to pay an extra £15 000-£20 000 each year in pension growth tax.

"To further complicate matters, my accountant won't know the figure for 2017-18 until approximately October 2019, and for 2018-19 the figures won't be available until October 2020," he adds.

Capita often sends GPs pension savings statements for the tax year after the deadline for "scheme pays"—essentially, a high interest loan that reduces your pension. If this happens GPs have to estimate their pension growth, which is complex, and they risk fines and interest from HMRC if they get it wrong.

HEAD TO HEAD

Is an opt-out system likely to increase organ donation?

As England's deemed consent law is passed by MPs, **Veronica English** and **Emma Johnson** say that evidence from Wales and elsewhere shows it could increase transplantation rates. But **Blair Sadler** and **Alfred Sadler** argue legal changes are a distraction that lack strong evidence while public education and trained staff have a proven impact

yes

Welsh legislation allows people to opt in to donation as well as opt out, and 41% of the population have now opted in

Veronica English, head of medical ethics and human rights and policy lead on organ donation, BMA, London venglish@bma.org.uk

Emma Johnson, mother of patient Max Johnson, Cheshire

In an opt-out system for organ donation, dead donors' consent is presumed (or "deemed") unless there is evidence they did not want to donate. Opt-in systems, as in England currently, require donors to give explicit consent while alive or require families' consent. In both systems, families are consulted.

Moving to an opt-out system can raise organ donation rates, helping to save and transform lives. A growing evidence base shows this to be the case when opt-out is introduced with public support and as one part of a broader strategy including publicity, education, and infrastructure improvements.

People like Max Johnson might benefit: he had a lifesaving heart transplant at age 9. "Max and Keira's Law," the opt-out law due to come into force in England in 2020, is named after him and Keira Ball. She died aged 9, and her father gave permission for Max to receive her heart.

International comparisons, using statistical methods to account for other factors affecting donation rates (such as health expenditure and mortality after road traffic incidents), show increasing evidence that an opt-out system is one of several factors associated with higher donation rates.

In 2008 a systematic review identified four methodologically sound comparative studies, all of which found that opt-out laws or practice were associated with increased donation rates. An update of this review by the Welsh government in 2012 and an evidence review by the Scottish government in July 2018 found similar evidence.

Learning from Wales

Extrapolating from other countries is difficult. But the shift to deemed consent in Wales in December 2015 provided a unique opportunity to assess the effects on the UK's organ donation programme. Although it is too early to assess the full impact of this change, the signs are positive. The number of deceased donors has increased (from 61 in 2016-17 to 74 in 2017-18 and 72 in the first three quarters of 2018-19). In addition, NHS Blood and Transplant's latest quarterly review of cumulative data shows a statistically significant rise in the consent rate among brain dead donors in Wales compared with England. Other findings from Wales also support an opt-out approach:

- Recent data show 73% support from the public for deemed consent (up from 49% in 2012 before the legislation was passed), as well as 85% support from NHS staff
- An integral part of the change to an opt-out system is publicity and education, and the legislation acts as a catalyst for this investment and engagement. In Wales more people have discussed their wishes with their families, which makes it easier for healthcare staff to talk to families about donation and less likely they will object
- The Welsh legislation allows people to opt in to donation as well as opt out, and 41% of the population have now positively opted in (up from 34% in 2015)
- Only 6% of the population have opted out, which is as expected from public surveys
- The specialist nurses and clinical leads working in the new system have reported a smooth transition.

The rest of the UK has shown considerable public support for an opt-out system, which is crucial to its success. A poll commissioned by the BMA in 2017 found that 65% of 2011 respondents in England, Scotland, and Northern Ireland supported the idea of following Wales.

Part of a broader strategy

Opt-out alone is not the answer. But—when it is introduced with public support and publicity as part of a broader strategy, including improvements to the organ donation system to ensure that the facilities, training, and staff are in place—changing the default position can significantly increase organ donation, while giving people the same right to decide as in an opt-in system.

We have seen huge improvements to the infrastructure over the past decade with financial investment, an increase in specialist staff, and a more coordinated approach. We know about the public support for such a shift. The new opt-out law in England will now make it as easy as possible for people who wish to donate organs to do so.

no

Spain's longstanding high donation rates are the result of strong and sustained public education, and special training for intensive care staff

Blair L Sadler, lawyer and senior fellow at the Institute for Healthcare Improvement, Boston, Massachusetts bsadler@ucsd.edu

Alfred M Sadler, physician and senior adviser to California State University, Monterey Bay

Many medical, scientific, and operational improvements are steadily boosting the number of transplantations, but the gap between supply and demand continues to grow in many countries. For example, in the US, the number of transplants trebled over 20 years, while the number on waiting lists increased sevenfold. This is largely due to an obesity epidemic, leading to diabetes, and the corresponding increase in people on dialysis and the need for more kidney transplants.

This painful reality must be, and is being, dealt with. However, changing the law from opt-in (requiring explicit consent) to opt-out (deemed or presumed consent) is not the solution. Improving the current system is.

Over the past 50 years there have been calls for a change in legislation from opt-in to opt-out, promising this would provide a simple solution to problems that are much more complex. Advocates in England have stated in recent parliamentary hearings that the change would save lives, and an opt-out approach is scheduled to become law in 2020.

Superficial appeal

The opt-out system has superficial appeal, but it is illusory. A common narrative states that, because opinion polls show that most people say they would donate organs after death, we should legally presume they would. But data from other countries, allegedly showing that opt-out laws lead to higher donation rates, are weak and unpersuasive.

Many people cite Spain as an example of a successful opt-out system. It enacted an opt-out law in 1979 but saw no improvement in transplantation rates until a decade later, when significant improvements were made to its system. Rather than the opt-out law, Spain's longstanding high donation rates are the result of strong and sustained public education, as well as in special training for intensive care nurses and doctors. The director of Spain's programme has repeatedly stated this and has called the law "a distraction." In Brazil, a presumed consent law adopted in 1997 faced such a backlash that it was abolished the following year.

Evidence from Wales is inconclusive. Its opt-out law was implemented concurrently with major awareness campaigns and training for doctors and nurses. Thus, any increase in donations is more likely to be a result of these than the law itself. An accurate analysis of the law's impact must account for these factors.

Expert UK panels, such as the 2008 Organ Donation Taskforce commissioned by NHS Blood and Transplant and the Nuffield Council on Bioethics, recommended against an opt-out system. They concluded the change could risk undermining the altruism of donation and erode trust in a government system. By definition, the taking of organs rather than the giving of them can erode trust.

Two proven strategies

The alleged benefits of a soft opt-out law were illusory 50 years ago when first proposed, and they are today. It's time to separate the rhetoric (an opt-out law would save hundreds of lives) from the reality (the compelling evidence from Spain's systemic improvements cannot be ignored.) The proposed law in England oversells the benefits of opting out and undervalues the risks. It distracts from the two evidence based strategies shown to improve transplant rates and save lives:

- Undertake substantial and sustained public awareness campaigns that encourage people to become organ donors and encourage families to have conversations about organ donation
- Train nurses and doctors on how to engage in organ donation conversations with their patients and families.

Instead of wasting millions redesigning the legal system, focus on these aspects that have been shown to work in Spain, in the US (where 58% of the adult population are now registered organ donors), and elsewhere—while preserving trust in the NHS.

Max Johnson, Keira Ball, and her family are heroes. The altruistic decision by Keira's family saved four lives, including Max's. Their stories had the immediate, catalytic effect of stimulating more than 1000 people to register as donors without a law change. Imagine how many people would register if an awareness campaign told stories like theirs, repeatedly. This would truly honour Max and Keira and would facilitate the dedicated people who make the opt-in system work every day.

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PATIENT COMMENTARY

My three livers: how transplants have allowed me to live my life

By the time **Erin Walker** turned 20 she was on her third liver, after a second transplant. Seventeen years on she reflects how organ donation has enabled her to experience many of life's rites of passage

In 1979 the immunosuppressant ciclosporin had been developed, radically improving survival rates after organ transplantation. In 1983 transplantation was approved to treat end stage liver disease.

In January 1986, aged 4 and with primary sclerosing cholangitis, I had a liver transplant in Boston, US. We lived in Ottawa, Canada, and I'd been on three waiting lists because my health was so poor.

Waiting had been a time of grief and anguish. One liver came up for me around Christmas 1985, but I had an infection, and the transplantation could not go ahead. My parents thought that this had been my only chance, but another came soon after.

I'm unsure what I remember from that time and what my parents have told me since. It was a profound experience for my whole family. My parents were just 30 and 31. I'm the youngest of four siblings. My identical twin sister was, and has remained, healthy.

Nearly brown with jaundice

I remember feeling fear and trying to be brave for my parents. I've seen photos of a cheerful looking little girl, abdomen bloated with ascites and nearly brown with jaundice, but I have little recollection of her. What's striking is the juxtaposition with photos of my twin—rosy faced, bright eyed, and half a foot taller.

My childhood after transplantation was quite healthy. I caught up with my twin sister in cognitive and physical development. But worries about rejection plagued us occasionally.

At age 17 I developed chronic ductopenic rejection and was told that I'd need another transplant. I had thought that my transplant in 1986 had been curative.

I experienced profound depression and symptoms of liver failure. I dropped out of high school. But, with support and adjustment to my drugs, I caught up with my peers.

Every year my family and I celebrate my two liver transplant anniversaries, or "liversaries"

My health continued to decline, however, and I dropped out of university after a year or so. As I waited for another transplant I experienced another episode of major depression and debilitating fatigue. I would not have made it through that time without my family.

I became convinced that a liver wouldn't become available in time—that I'd die without experiencing most of life's rites of passage. Seven months later a suitable liver became available: it was September 2002, and I was only 20.

The happiest girl in the world

I described myself then as the happiest girl in the world. After recovery I returned to university full time, worked part time, and had a regular 20 year old's social life.

But I was devastated to have recurrent primary sclerosing cholangitis diagnosed the day I turned 24, in 2005. I'd suddenly become itchy: the pruritis with liver failure is striking. A doctor confirmed bacterial cholangitis and diagnosed recurrent liver disease. I felt dread, then desperation, and then depression again.

In the 14 years since then my health has fluctuated. I still have primary sclerosing cholangitis, and my liver is atrophying. I also have ulcerative colitis and chronic neuropathic pain. I continue to experience depression and have developed generalised anxiety disorder.

A marriage, a house, and a job

But, thanks to transplantation, I completed that undergraduate degree, a masters degree, and then a doctoral degree on quality of life for liver transplant patients. I moved to the UK, got married, bought a house, worked full time (I still do), and became an auntie. I've undergone many of life's rites of passage, and I'm happy.

No statistics are routinely collected for survivors 30 years after transplantation, but I suspect that the numbers are small. I am one, however, and every year my family and I celebrate my two liver transplant anniversaries, or "liversaries."

I often worry how long my current (third) liver will last and whether I'll have a third liversary to add to those two. It feels like a ticking bomb. I don't know that my mental health will be strong enough when I'm put on a waiting list. I don't want my family to have to care for me through another transplant operation, and I'm aware that outcomes become worse with increasing transplants.

People die every day waiting for a transplant because organ donation rates do not meet demand. Without a liver transplant I would have died in 1986. I'm extremely grateful for these extra 33 years, for most of which I've lived a normal and happy life.

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2019 BMJ AWARDS

FINALISTS

ANAESTHESIA AND PERIOPERATIVE MEDICINE

TEAM OF THE YEAR

CARE OF THE OLDER PERSON

TEAM OF THE YEAR

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UK INDEMNITY, ADVICE & SUPPORT

Anaesthesia and perioperative medicine team of the year

Shortlisted teams in this category are finding innovative ways to drive perioperative safety and efficiency, reports **Jacqui Wise**

REDUCING CANCELLATIONS

As a result of the project theatre session use rose from an average of 85% to 90%

Having an operation cancelled on the day is annoying and inconvenient for the patient and means that theatre time is not fully used.

Rebecca Barker, consultant anaesthetist and pre-op lead at Sherwood Forest Hospitals NHS Foundation Trust in Nottingham, analysed emails detailing on-the-day cancellations and thought they could do better.

"There were some common problems that we thought could be avoided—if patients had been unwell for a few days before the operation, for example, or if they had forgotten to stop taking their warfarin," she says.

The team remedied this by calling every patient five days before their scheduled operation to ask about their general health, check if they still needed the operation, and remind them of starvation and drug instructions. If a patient's operation had to be cancelled for any reason, then there was still time for the theatre slot to be backfilled from the waiting list.

As a result of the project, the on-the-day cancellation rate went down and session use in theatres rose from an average of 85% to 90%, leading to a projected saving of £250 000 over a year.

"Another advantage of the project was being able to identify near misses—if swabs had not been done, for example, or if something was missing on the paperwork," Barker says.

PERIOPERATIVE PHARMACY

Patients undergoing elective surgery often have existing comorbidities and are taking a number of drugs. The prescribing of routine drugs is often performed out of hours by on-call teams when the patient arrives on the ward post-surgery.

Wirral University Teaching NHS Hospitals Trust set up a dedicated pharmacy prescribing team to work alongside nursing staff, surgeons, and anaesthetists in the surgical elective admissions lounge. Tara Molloy, highly specialised pharmacist independent prescriber and team leader, says: "Previously, it was taking an average of 36 hours from drugs reconciliation to a proper prescribed drug chart. Now we can get prescriptions generated within 43 minutes so a patient doesn't miss any of their critical drugs."

The team assesses all the patient's drugs including over-the-counter and herbal medicines

The pharmacy team assesses all the patient's drugs including over-the-counter and herbal medicines, as well as those from a tertiary centre. It checks whether the patient is taking the drugs appropriately and if they are going to interact with the anaesthetic and are appropriate to take in the period after surgery.

They also assess whether a patient's own drugs can be used during the hospital stay, which has led to cost savings. The scheme also frees up beds as patients can be discharged earlier as they are not waiting for drugs to be dispensed.

ARTERIAL LINE SAFETY

Drugs must never be given into the arterial line. If it happens it can damage the blood supply to the hand and lead to ischaemia, tissue necrosis, and sometimes amputation.

"It is used in a third of NHS hospitals. We believe it is the most evidenced widget to come into practice"

Around 10 years ago a team from the Queen Elizabeth Hospital in King's Lynn designed a non-injectable arterial connecter which ensures that clinical staff can always take a blood sample but never inject into an artery (www.kipsuk.com). The connecter has been developed through the NHS Innovator Accelerator programme and hospitals are fully reimbursed for its use.

"It has been a long, slow process but it is now used in around a third of NHS hospitals," says Peter Young, consultant in intensive care medicine. "We believe it is the most evidenced widget ever to come into practice," he adds.

The team has shown that the connecter prevents bacterial contamination of the arterial line. Currently most UK hospitals change their arterial line transducer sets every three days, although a minority follow European every seven days guidance. The team demonstrated that using the connecter meant there was zero bacterial colonisation of the transducer set even at seven days. Extending the life of the transducer sets saved the hospital £10 000 a year and would save an estimated £10m for the NHS annually in equipment terms alone.

RCoA
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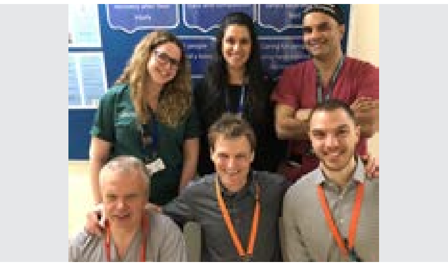
The anaesthesia and perioperative medicine team of the year award is sponsored by the Royal College of Anaesthetists. To find out more go to **thebmjawards.bmj.com**

2019

FASCIA ILIACA BLOCK PROJECT



National guidelines recommend fascia iliaca blocks (FIBs) for patients with neck of femur fractures in order to minimise the need for opioids and non-steroidal anti-inflammatory drugs. The national Hip Fracture Database showed that the Queen Alexandra Hospital in Portsmouth was in the bottom half of the overall national rankings for performing these blocks.

The main problems identified were the time needed and a lack of trained staff, says Michael Apostolide, core surgical fellow in trauma and orthopaedics. A collaboration between the emergency and trauma and orthopaedic departments resulted in the development of a specially designed FIB trolley for use in the emergency department and a FIB bag for use on the wards. These contain all the equipment needed to perform a block including local anaesthetic, syringes, needles, and packs.

The percentage of patients receiving a FIB has risen fourfold to 82%—30% higher than the national average

"Before, the average time taken to perform a block was 30 to 40 minutes because of the time taken to find all the equipment—now it's less than 10 minutes," says Apostolide. The bag and trolley also contain labels and guidelines so the process has helped to improve safety. The second aspect of the project was to organise regular training for junior doctors and nurse practitioners.

As a result of the project, the percentage of patients receiving a FIB has increased fourfold to 82%—30% higher than the national average.

PERIOPERATIVE TRAUMA CARE

The percentage of patients with no pain or mild pain after 24 hours went up from 78% to 94%

As the elderly population increases, so too do the number of patients presenting with hip fractures and who typically have multiple comorbidities. Disappointing results in the National Hip Fracture audit led the team at Sandwell and West Birmingham NHS Trust to start a seven day, consultant led "perioperative trauma care bundle" to improve outcomes in these patients.

Ahmed Gilani, specialty trainee in anaesthetics, says elderly patients with a neck of femur fracture are first seen by a dedicated perioperative anaesthetist who oversees the needs of each patient. Anaesthetic practice has been standardised to emphasise spinal anaesthesia with FIBs and avoid agents that cause delirium. All five trauma care practitioners have been trained to perform FIBs and a "Stop before you block" system was instituted to reduce the number of wrong sided nerve blocks.

As a result of the bundle of initiatives, the uptake of patients having FIBs increased from 28% in 2014 to 96% in 2018. The percentage of patients with no pain or mild pain between recovery and 24 hours postoperatively went up from 78% to 94%.

"We have managed to reduce postoperative delirium rates from 67% to 34% and reduced the length of stay in hospital from 19 to 15 days," says Gilani. "We also involve the family or carers early on to discuss risk, treatment, and resuscitative status."

POST AMPUTATION PAIN MANAGEMENT

Pain management after amputation is extremely challenging and is highly correlated with chronic pain problems, says Rita Singh, consultant anaesthetist at the Freeman Hospital in Newcastle. It is further complicated because patients tend to be elderly with significant comorbidities, such as diabetes or renal problems, and as a result are taking many drugs. The Acute Pain Service at the hospital was regularly requested to review patients with post amputation pain and felt that management could be improved.

"Keeping the perineural catheters for seven days helps to avoid postoperative delirium"

In 2016 a new approach was initiated in which, following a lower limb amputation, patients were given a low dose local anaesthetic infusion for seven days through a perineural catheter. As a result of the initiative, mean movement pain scores over 72 hours dropped to 1.2 out of 10, compared with 4.48 out of 10 in the period 2014-2016. The mean length of stay decreased from 38 days to 28 days for above the knee amputation, and from 39 days to 30 days for below the knee amputation.

Singh says, "Keeping the perineural catheters for seven days helps the patients avoid chronic pain in the long term and avoids the need for opioids. It also helps to avoid postoperative delirium which can be a problem in this age group."

Feedback has been positive with ward nurses noticing that patients have improved mobility, more energy, and are more willing to partake in rehabilitation and limb fitting.

Care of the older person team of the year

A holistic approach focused on the needs of patients has enabled the shortlisted teams to improve the quality of care, reports **Jacqui Wise**

ACUTE FRAILTY PATHWAY

The biggest growth in unplanned care and emergency department attendance is in older people living with frailty. The Royal Surrey County Hospital NHS Foundation Trust found that frail over 75 year olds were poorly identified and likely to breach the four hour waiting time targets.

In order to tackle the problem, the hospital instituted a "big room" approach adapted from the Toyota production system, says James Adams, consultant geriatrician and clinical lead for the project. Once a week there is an open invitation for doctors, therapists, nurses, and healthcare assistants to meet with a data analyst and use quality improvement methodology to pick apart the problems and work out solutions.

The overall median length of hospital stay was reduced by 24%, from an average of four to three days

"The result has been a cultural change. We now have identification of frailty as soon as a patient comes into the emergency department. We then have a multidisciplinary team that deliver a comprehensive geriatric assessment," says Adams.

The project has reduced the time frail elderly patients spend in the emergency department by 19%—down from 4.4 hours to 3.6 hours. Same day and next day discharges from the emergency floor have also increased. The overall median length of hospital stay was reduced by 24%, from an average of four to three days, and the mean length of stay was reduced by 14%, from an average of nine to seven days.

UTIS IN THE ELDERLY

In September 2018 prescription of trimethoprim for the over 75s was nearly half what it was in April 2017

Public Health England does not recommend using urine dipsticks to diagnose urinary tract infections (UTIs) in the elderly because, in this age group, there is a certain amount of bacteria present in the urine even if there is no infection. In practice, however, dipsticks are still used, particularly in care homes, says Mini Satheesh, Health Needs Neighbourhoods pharmacist for Leicester City clinical commissioning group (CCG). This leads to many elderly people being given antibiotics unnecessarily.

NHS England has set targets for reducing the number of prescriptions for trimethoprim, an antibiotic that is often given to patients aged over 75 with suspected UTIs. The prescribing teams at the three CCGs in Leicestershire worked together to produce a simple template for care homes with a tick box of symptoms that could be given to the GP.

They also developed a diagnostic algorithm which was incorporated into the computer systems used in all the area's GP practices. This helps GPs make an accurate diagnosis and gives advice on which drugs to prescribe, taking into account any allergies. The read codes are recorded simultaneously for all the symptoms that the GP ticks along with the final diagnosis, which saves time during consultation.

The project has had positive results—figures for September 2018 show that prescription of trimethoprim for the over 75s is nearly half what it was in April 2017 across all three CCGs.

CHANGING THE CULTURE OF CARE

A 30% rise in unscheduled admissions in patients over the age of 80 and a realisation that those with frailty were managed poorly prompted a massive rethink at the University Hospital Southampton. "We wanted to change how everyone—from commissioners to managers and clinicians—thinks about how we manage older people," says Daniel Baylis, consultant physician and care group clinical lead.

The project has looked at improving the experience of the patient. "Now, as soon as an elderly patient is dropped off by an ambulance at the emergency department they are taken to a new, purpose built area of the hospital which is a nice and calm space. A few years ago they would have sat for four to five hours on a trolley," says Baylis. Patients are seen immediately by a geriatrician, with a third able to be discharged home. The time from admission to senior decision making has reduced from eight to two hours.

Patients are encouraged to wander around the unit so they are kept functionally active

A charity fundraising scheme has created a hub activity centre on the wards. This offers exercise classes, cinema nights, meals, and activities. Patients and their relatives are encouraged to wander around the unit so they maintain their muscle mass and are kept functionally active. The project has also resulted in the average length of hospital stay reducing from 14 days to eight.

The care of the older person team of the year award is sponsored by the Dunhill Medical Trust. To find out more go to **thebmjawards.bmj.com**

BRISTOL DEMENTIA WELLBEING

In Bristol in 2014 the dementia diagnosis rate, which compares the number of people thought to have dementia with the number of people diagnosed with dementia, was only 50%, with those from black, Asian, and minority ethnic communities particularly underrepresented. The Bristol Dementia Wellbeing Service was set up in partnership with the Alzheimer's Society to improve early diagnosis and introduce personalised wellbeing planning. The city now has the best diagnosis rate in the south west at over 75%.

> "The aim is to enable people to stay as well as possible, as connected as possible, in their own homes"

All GP practices have a named dementia practitioner to work on a person's clinical needs and a dementia navigator who identifies community activities that can enhance wellbeing and quality of life. One such is the Woodland Wellbeing group, which offers activities such as Tai Chi, fire pit building, poetry, or collage.

Stephen Collings, contract business manager for the service, says: "Previously, there was uncoordinated support—a person would have had a dementia diagnosis and then been left to fend for themselves a little bit. Dementia is now managed as a long term condition. The aim is to enable people to stay as well as possible, as connected as possible, in their own homes."

The service has a number of community development coordinators to improve access to services in underrepresented communities. And to tackle some of the myths and stigma it has published short films in Cantonese, English, Polish, Punjabi, Somali, and Urdu.

BETTER CARE FOR OLDER ADULTS

Older patients tend to stay longer on psychiatric wards as a result of physical comorbidity and complex care needs. East London NHS Foundation Trust—like many other trusts—needed to reduce bed numbers to preserve community services and centralise resources. "We had patients who had been on the ward for years," says Waheed Fawzi, consultant psychiatrist and lead clinician at the trust.

The team made a number of changes to reduce length of stay and improve the discharge process. "We stopped the weekly psychiatric ward round which can be intimidating for patients. Instead we held a daily management meeting in which all of a person's needs were discussed by the multidisciplinary team. As a result, doctors, nurses, and therapists had more time to spend with each patient."

Another initiative was a weekly meeting to discuss the five longest stay patients to identify any barriers for discharge. In 12 months the team reduced the length of stay from an average of 47 days to an average of 30 days and reduced bed occupancy from 77% to 54%. "People with mental health problems generally have poor access to physical healthcare," says Fawzi. "But because of the amalgamation of wards we were able to pool resources so we had more to offer, such as physiotherapy, intensive occupational therapy, diabetes nurses, and chiropody. The patients are getting much better access to treatment now."

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MANAGING FRAILTY PROACTIVELY

Emergency admissions for subjects of a frailty multidisciplinary team meeting have fallen by 46%

Surrey Heath has a high proportion of over 60 and over 80 year olds and these populations are projected to grow faster than the national average. The Surrey Heath frailty project was created to identify and support people living with frailty in order to prevent emergency admissions and maintain independence. "We were looking at providing more proactive and anticipatory care for these patients," says Emma Whitehouse, GP and clinical lead for end of life care and frailty at the CCG.

Patients identified with severe or moderate frailty are discussed at a weekly multidisciplinary team meeting, which involves primary care, social care, mental health, community nursing, rapid response and community rehabilitation, and occupational therapists and other specialists. A consultant geriatrician also provides input over the telephone.

"We work through a panel of interventions for each patient. For example, do they need a community nurse review, referral to a specialist in hospital, a fire risk assessment, or podiatry to ensure their footwear is correct? It's an holistic approach," says Whitehouse. "Because we can all access our computer systems we can answer questions such as whether a patient has had a carer's assessment immediately."

There has been a 46% reduction in emergency admissions for patients discussed at a frailty multidisciplinary team meeting. Patient feedback has been positive and a staff survey found that 94% said patient care had benefited.

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