this week

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RCGP votes no to PAs in general practice

The Royal College of General Practitioners has changed position to oppose physician associates working in general practice after a vote by council members on 20 September in which 61% agreed to oppose the role of PAs working in general practice, 31% disagreed, and 8% abstained.

In June the RCGP called for an immediate freeze on PA recruitment until regulation and scope of practice guidance were finalised.

The RCGP council has approved three sets of guidance to support practices that employ the 2000 PAs working in general practice, which will be published in the coming weeks.

The council opposed a paragraph in the draft guidance stating that, if existing PAs are practising beyond the scope described in RCGP guidance, it is the responsibility of their GP clinical supervisor or their employer to determine that they are doing so safely. This paragraph will be removed to ensure it is clear that PAs must always work within the scope of practice that the RCGP will set out.

In a statement the college said its position remained that regulation of PAs by the GMC must proceed as soon as possible, although it held that a "regulatory body other than the General Medical Council would be more appropriate to take forward this crucial work."

The GMC will begin regulating PAs and anaesthesia associates at the end of the year. RCGP chair Kamila Hawthorne said, "The role of PAs in general practice has dominated the medical agenda for well over a year, and we understand the strength of feeling among our members and their concerns for the safety of their patients.

"It became clear at the council discussion we needed to speak out in opposition to the PA role in a general practice setting, and I am pleased that our processes have enabled us to do this in a collegiate and democratic way."

The RCGP's change of heart follows a long dispute between the Royal College of Physicians of London and its membership. An open letter signed by 32 RCP fellows, published in *The BMJ* on 17 September, said parliament was misadvised when the RCP was cited as approving legislation giving the GMC powers to regulate PAs.

An independent inquiry by the King's Fund concluded that the RCP was dysfunctional in its handling of members' concerns. It noted that, had the extraordinary general meeting called for by members been held before the House of Lords debated the matter, this may have affected the passage of the legislation.

▶ HELEN SALISBURY, p 360

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;386:q2078

Kamila Hawthorne, RCGP chair, said she was pleased with the "collegiate and democratic way" members' views had been acted on

LATEST ONLINE

- US has worst healthcare outcomes while spending the most, study shows
- Parliament was "misadvised" regarding RCP's support for regulation of physician associates, fellows say
- Donanemab: Conflicts of interest found in FDA committee that approved new Alzheimer's drug

SEVEN DAYS IN

Paediatricians urge action to protect children from air pollution risks

The government must take stronger action to protect children from the serious health harms of fine particulate matter ($PM_{2.5}$) and nitrogen dioxide, the Royal College of Paediatrics and Child Health has urged in an updated position statement.

Children are especially vulnerable to air pollution because they inhale more air than adults in proportion to their body weight, breathe closer to sources of pollution such as vehicle exhausts, and are less able to control their exposure than adults, the college said.

Exposure to air pollution has also been linked to slower response times and decreased attentiveness among schoolchildren and to mental health problems such as psychosis, the statement said. It recommended action to monitor air quality in schools and empowering local authorities to act when pollution exceeds limits. A Clean Air Act should also be enacted to establish a legal right to clean air across all four UK nations and should also commit their governments to WHO's air quality guidelines.

Mike McKean, a college vice president and a paediatric respiratory consultant, said, "Exposure to air pollution is now the second leading risk factor for death in children under 5, both globally and in the UK. Immediate action is needed."

Gareth Iacobucci, *The BMJ* **Cite this as: *BMJ* 2024;386:q2071**

Cancer

Charity calls for long term strategy to tackle delays

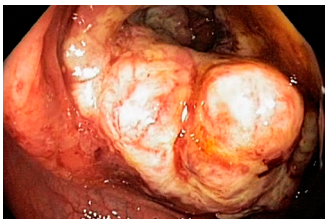
More than 301 000 people with cancer in England will begin treatment later than they should over the next five years if the government fails to ensure that performance improves, said Cancer Research UK. The charity's projections show that England will have around 17.2 million urgent suspected cancer referrals in the next five years. In the first six months of 2024 just 65.9% of patients with cancer were treated within the target time of 62 days from an urgent referral, meaning that more than 30 000 patients did not start treatment on time.

New treatment for AML is approved by NICE

Quizartinib, a new targeted treatment, can now be prescribed for new patients with a specific form of acute myeloid leukaemia (AML). Of the 3100 people a year who have AML diagnosed in the UK, 27% have the *FLT3*-ITD genetic mutation and can benefit from the daily tablet. Helen Knight, director of medicines evaluation at NICE, said, "Clinical evidence found patients taking quizartinib had an average overall survival of almost 32 months, compared with just over 15 months for those receiving the placebo, and our independent committee found it to be a cost effective treatment."

Regulator approves colorectal cancer drug

The Medicines and Healthcare Products Regulatory Agency has approved fruquintinib (Fruzaqla) to treat adult patients with metastatic colorectal cancer when other treatments have not worked. The treatment stops tumours from making new blood vessels, thereby



slowing the growth of cancer. One study conducted in 416 adults in China found that those treated with fruquintinib lived for an average of 9.3 months, which compared with 6.6 months among those taking a placebo. A common side effect is a reduced number of blood platelets, which can result in easy bruising or bleeding.

Concussion

FIFA and WHO launch global awareness campaign

The World Health Organization has launched a campaign to highlight the risks of concussion and provide educational resources for people involved at any level of football. Suspect and Protect: No Match is Worth the Risk, which is supported by FIFA member associations, aims to increase symptom recognition among players, coaches, and medical staff, as well as the public. The campaign highlights that symptoms can take 72 hours to appear and offers guidance on how to return to play safely after suspected or confirmed concussion.

Benefits

Health related welfare claims rise sharply

The number of working age people in England and Wales receiving health related benefits has risen sharply over the past four years, shows an analysis by the Institute for Fiscal Studies funded by the Joseph Rowntree Foundation and the Health Foundation. Some 3.9 million people (10% of the working age population) received health related benefits in 2023-24, up from 2.8 million (7.5%) in 2019-20. Every local authority in England and Wales apart from the City of London saw an increase in claims, and the official forecast is for further growth by 2028.

Abortion

Buffer zones 150 m wide to surround UK clinics

Protection zones around abortion clinics in England and Wales come into force on 31 October. The zones will make it illegal for anyone to influence someone's decision to use abortion services, obstruct them, or cause harassment or distress to someone using or working at the premises. The law will apply within a 150 metre radius of the abortion service provider. Jess Phillips, minister for safeguarding, said, "The right to access abortion services is a fundamental right for women in this country, and no one should feel unsafe when they seek to access this."

Safe access zones around abortion services came into effect in Scotland on 24 September after a law was passed to prevent people trying to scare women and girls away from clinics and hospitals.

MEDICINE

Ophthalmology

Third of children and teens are shortsighted

A global review has found that from 1990 to 2023 the overall prevalence of myopia in children and teenagers more than tripled. The review of 276 studies found prevalence of shortsightedness had risen from 24% in 1990-2000 to 36% in 2020-23. The review predicts this will reach around 40% by 2050, exceeding 740 million cases. Factors include living in east Asia and urban areas, female sex, and high school education.

World prevalence of myopia in children is predicted to reach 40% by 2050

Mpox

Europe extends vaccine indication to adolescents

The European Medicines Agency has recommended extending the indication of the Imvanex smallpox and mpox vaccine to adolescents aged 12 to 17. The vaccine is

already authorised in adults. The new recommendation is based on interim results of a study in 315 adolescents and 211 adults, which found a similar immune response and safety profile in both groups. The World Health Organization has declared an mpox outbreak in the Democratic Republic of the Congo to be a public health emergency.

Nipah

Kerala reports second death in four months

A 24 year old student who was visiting his home town in Kerala is the second person to die from Nipah virus in the Indian state this year. The first was a 14 year old boy who died in June. Since 2018 Kerala has had 22 Nipah deaths, and outbreaks are becoming more frequent. The outbreak is the sixth since 2018 and the second this year, said officials. WHO lists Nipah as a priority pathogen, with high potential to cause pandemics.

Health outcomes

US performs worst among rich nations

The US spends more on healthcare than other prosperous western countries but its citizens die four years earlier, said the Commonwealth Fund, which compared US healthcare with nine other prosperous nations. On the five areas measured (access to care, the care process, administrative efficiency, equity, and health outcomes), the three top performing countries were Australia, the Netherlands, and the UK. Australia (9.8%) also spent the least on healthcare as a proportion of its GDP when compared with the US, which spent 16.5%. Access to care was best in the Netherlands, the UK, and Germany.

Cardiology

Women "underdiagnosed and undertreated"

Representatives of cardiovascular, nursing, and patient bodies linked to the British Cardiovascular Society have called for a women's health strategy, heart champions, and dedicated heart hubs. They said in a consensus statement that despite major progress women continued to be underdiagnosed, undertreated, and under-represented in clinical trials in all areas of cardiovascular disease.

Cite this as: *BMJ* 2024;386:q2087

FGM

Female genital mutation was identified at **14 355** attendances at NHS hospitals or general practices in 2023-24, up **15%** from 12 475 in 2022-23

[NHS Digital]

SIXTY SECONDS ON . . . NHS REFORMS

I'M GETTING A FEELING OF DÉJÀ VU

This time it's the Policy Exchange, the right leaning think tank, calling for NHS England to be abolished as an independent commissioning body and for its key functions to be delivered by an NHS management board within the Department of Health and Social Care (DHSC).

ISN'T CONSTANT REORGANISATION PART OF THE PROBLEM?

Yes, Ara Darzi's recent damning report said the NHS was in a "critical condition," partly as a result of the "disastrous" structural reforms in 2012.

SO, ANDREW LANSLEY IS TO BLAME?

His 2012 reforms did create NHS England. But the think tank's report argues we now need a "rebalancing," with less central bureaucracy; a limited number of functions "to be overseen and held more tightly by ministers and others more loosely"; and greater autonomy for managers and clinicians. There should also be an overhaul to improve operational performance, with more effective procedures to dismiss underperforming managers, it says.

IS THIS ABOUT MANAGER NUMBERS?

The report argues it's flawed to focus on numbers. The NHS is "undermanaged" when compared with other sectors and international comparators but "not as much as is often cited." But there has been substantial growth in managers working in central bureaucracy. For example, NHS England and the DHSC employ 19 000 managers between them.

THAT DOES SOUND A LOT

Too many structural tiers of management have created "layers of complexity and reduced accountability," according to Policy Exchange. "Effective management is key to improving NHS performance, but it would be a mistake to think more managers will inevitably lead to improvement," says John Power, the report's lead author. "We have more managers, but they aren't optimally placed."

WHAT'S THE REACTION BEEN?

Jeremy Hunt (above), the former Tory health secretary, has called the proposals "bold and pragmatic." NHS England, perhaps unsurprisingly, says reorganisation is "neither necessary nor desirable."

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;386:q2072

NHS in Wales and England to tackle wait lists together

The UK and Welsh governments have agreed to work together to help deliver better care and reduce waiting times for hospital care and dentistry.

Speaking at the Labour Party conference in Liverpool on 23 September, Jo Stevens, the Welsh secretary, said, "I am proud to announce a new partnership between our two Labour governments to drive down NHS waiting lists on both sides of the border. The UK government will take inspiration from Wales on dentistry, where reforms have already unlocked almost 400 000 appointments in the last two years—and we're a nation of only three million people.

"And the Welsh government will benefit from best practice shared by NHS England as my colleague Wes Streeting oversees the rollout of new, more productive ways of working to deliver those 40 000 extra appointments every week. This is the beginning of a new way of working together that will help improve outcomes in both nations and deliver on our missions."

In July this year a record number of 616 669 people in Wales were waiting for treatment through the NHS.

Mabon ap Gwynfor, Plaid Cymru's health and social care spokesperson, criticised the plan, describing it as "cosmetic" and saying it failed to "offer the radical action required to address the underlying crisis faced by the Welsh NHS."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;386:q2096

LIONEL WOTTON / ALAMY

CQC **Poor care normalised as two thirds of maternity units fail to meet safety standards**

Poor care in maternity services is being "normalised," the Care Quality Commission has warned, as it urged the NHS and the government to act to prevent further harm to women and babies.

The regulator's maternity inspection programme of 131 units in England from August 2022 to December 2023 found some examples of good practice but also revealed that nearly half of units (48%) were rated as "requires improvement'" or "inadequate" overall. Notably, only 35% of units were rated "good" for safety, while nearly half (47%) were rated as "requires improvement" and 18% were rated "inadequate."

"We found significant variation in the way trusts operated in key areas such as learning from incidents and triage," the report said. "In addition, the high levels of challenge we received from some leaders working across the sector led to concern that poor care within maternity is being normalised."

In many units serious incidents were not reported, the inspections found, and there was a tendency to accept incidents as inevitable. Also, some units lacked the required space and facilities, including, in a small number of cases, the appropriate level of lifesaving equipment.

Some trust staff and patients also reported experiences of discrimination because of their ethnicity or because English was their second language. The CQC said communication with patients' families was generally not good enough and more work was needed to

COVID INQUIRY **UKHSA chief is challenged over FFP3 masks**

A top public health official caused a stir at the UK Covid Inquiry when questioned about the evidence for high grade face masks, specifically FFP3s.

Susan Hopkins (below), the UK Health Security Agency's chief medical adviser and former deputy director of Public Health England's national infection service, said discussions in December 2020 concluded that the evidence to recommend FFP3 masks "was very weak." Early in the pandemic PHE recommended that healthcare workers wear fluid resistant surgical masks and that FFP3s be reserved for those carrying out aerosol generating procedures such as intubation. NHS guidance was updated in mid-2021 to make FFP3 masks more widely available where the risk of infection was deemed high. However, doctors continued to call for all staff who were seeing patients to have access to these high grade masks.

Earlier in the hearing Hopkins cited the "harms from wearing FFP3s," including "blistering on faces." She said, "There were significant harms. I think that, from my point of view, having these discussions in the middle of a pandemic is very challenging, that we need to have an ongoing discussion and ongoing evidence about whether these masks actually do protect people better in real life settings in wards."

Real world evidence

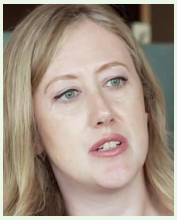
The inquiry's chair, Heather Hallett, said Hopkins's remarks on the lack of strong evidence for FFP3 masks had caused a "great degree of consternation among many in this room" and that she wished to "challenge" them.

Hallett then displayed a surgical and an FFP3 mask. "As a layperson, just putting that [surgical mask] on, there seems

ensure all maternity patients were given the information they needed to make informed decisions and consent to treatment.

The CQC has set out recommendations for trusts and integrated care boards, including ensuring they collect the right demographic data to review and act on safety incidents.

The regulator has also called on NHS England to work with the Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists to "establish a minimum national standard for midwives delivering high dependency maternity care." It urged the Department of Health and Social Care to provide additional, ringfenced funding for maternity services.



We cannot allow an acceptance of shortfalls that are not tolerated in other services Nicola Wise

We know there is much more we need to do to drive up standards of care Kate Brintworth

"We must do more"

Nicola Wise, CQC's director of secondary and specialist care, said, "We cannot allow an acceptance of shortfalls that are not tolerated in other services. Collectively, we must do more as a healthcare system. This starts with a robust focus on safety to ensure that poor care and preventable harm do not become normalised and that staff are supported to deliver the high quality care they want to provide for mothers and babies."

NHS England's chief midwifery officer, Kate Brintworth, said, "We know there is much more we need to do to drive up standards of care and build on improvements already made. We will continue to provide intensive support to the most challenged trusts and support growth in the maternity workforce."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;386:q2051

INSPECTORS rated **48%** of units as "requires improvement" or "inadequate"

to be lots of gaps, it's quite flimsy but, putting that [FFP3] on . . . surely just looking at it, that offers so much more protection—it must do, mustn't it?" she said.

Hopkins agreed there might be a difference between the masks in a laboratory setting but emphasised her focus was on what the real world evidence showed when these masks were worn for 12 hour shifts, day after day. When looking at this, she said, there was only weak evidence that FFP3 masks offered better protection.

Hallett asked Hopkins whether evidence would remain "weak" until randomised controlled trials produced "positive results." Hopkins replied, "In the terms of how we grade our evidence that's true, but I think what that means is that we need to do those trials properly, not just for covid but for other respiratory viruses that circulate, because otherwise we are not advancing knowledge in the way that science advances knowledge."

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;386:q2075

Former GP is struck off for spreading conspiracy theories about pandemic

A former GP who spread conspiracy theories about the covid-19 pandemic in online interviews has been struck off the medical register after a tribunal found he had abused his position as a doctor to undermine public health.

In five interviews from June 2021 to July 2022 posted online, Samuel White, who qualified at the University of Wales in 2004, acknowledged that the coronavirus was real but said it had been created by "globalists."

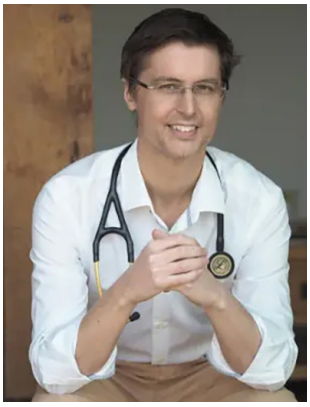
The pandemic "was planned at least a decade ago," he said—naming Bill Gates, Elon Musk, "Big Pharma," the "deep state," national governments, and the World Health Organization as actors in the alleged conspiracy.

Doctors were also agents of the conspiracy, White alleged. "This is tyranny," he said in one interview. "We never thought we would see this totalitarian, you know, sort of regime ushered in ever again and yet here it is, and they've done it, you know, via using doctors again and manipulating science."

In one interview he was introduced as a "rare breed: a doctor who is prepared to publicly speak out when he sees obvious danger signals that his profession is not acting in the best interests of the public." The presenter went on to say, "I will be discussing today with Dr White some of the lies that the medical profession might be promoting and the truths that they are trying to conceal."

Baseless claims

White, who had resigned his post as a GP in Hampshire before making the videos, did not attend his medical practitioners tribunal hearing. The tribunal, having quickly established the facts by viewing the videos, weighed the question of whether White's comments were protected free speech under the European Convention on Human Rights, which is enshrined in UK law by the Human Rights Act 1998. That act holds that free speech is a right that "may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity, or public safety."



This is tyranny . . . using doctors and manipulating science Samuel White

The limits of free speech for doctors in a public health emergency were delineated last year in the case of Mohammed Adil, who appealed against his suspension for making similar conspiracist comments online about covid. The Court of Appeal upheld that suspension.

The GMC asked for a suspension in White's case, but the three member tribunal panel chose to erase his name from the register. The tribunal chair, Malcolm Dodds, determined that "suspension of Dr White's registration would not be appropriate and would not be sufficient to send a message to the profession and the wider public about the gravity of the misconduct."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2024;386:q2046

GPs in most ICB areas saw enhanced service funding squeezed last year

BMJ INVESTIGATION

BMJ investigation finds commissioners' budgetary decisions are reducing practices' ability to offer key basic services and forcing some practices to close, reports **Gareth Iacobucci**

The truth and tragedy is the embarrassing paucity of discretionary investment that goes into essential services Katie Bramall-Stainer

EXCLUSIVE An investigation by *The BMJ* has found that four fifths of England's integrated care boards (ICBs) either reduced or froze the discretionary funding they gave to general practices as a proportion of their overall budget this year for services such as phlebotomy, anticoagulation monitoring, wound care, ECGs, and minor surgery.

For nearly half of ICBs this was the second year in a row GPs' budgets were squeezed for enhanced services (those outside the core contract).

The BMJ found examples of millions of pounds being stripped from local budgets. The sharpest reduction in 2024-25 was in Shropshire, Telford, and Wrekin ICB, which halved its discretionary spend on primary care services from £4.5m to £2.3m.

Katie Bramall-Stainer, chair of the BMA's General Practitioners Committee for England, said the findings indicated the scale of financial pressure on GPs' income and why practices were taking collective action—such as limiting how many patients they see each session and stopping rationing referrals—to drive home to the government the urgent need for greater investment in primary care. Many practices are facing financial ruin because of the combination of lack of funding, soaring costs, and high inflation, she said.

She added, "Nationally, this is an incredibly important piece of work that shines a light on what practices and local medical committees have suspected for years: this often overlooked aspect of the disparities in local enhanced services and local commissioning."

While ICBs have reduced their spending on enhanced services, the cost of providing them has gone up, which means "the maths doesn't work" for GPs, said Bramall-Stainer. "The truth and tragedy is the embarrassing paucity of discretionary investment that goes into these essential GP services. Hospital colleagues would be shocked to see such basic commissioning as ECGs, complex dressings, or phlebotomy services being commissioned this way at such low cost as to be financially unviable. It helps explain collective action and shows why we need a new national contract."

What is discretionary funding?

For GP services, discretionary funding applies to services outside the core contract. Under the terms of the 2004 General Medical Services contract, general practices in England can be given additional funding for providing extra services.

Typically, this comes through a mix of directed enhanced services (DESs), negotiated nationally, and local enhanced services (LESs), negotiated between local medical committees and ICBs. Enhanced services make up around 10% of GP income overall, or around £165 000 for an average sized practice of 10 000 patients, although this varies by local area and by practice, as services are optional.

LESs are designed to allow flexibility to cater services to local needs, but the level to which they are funded depends on local systems. *The BMJ's* investigation (see box for key findings) shows that this funding has come under increasing pressure as ICBs have been forced to make savings in recent years.

The current contract needs resetting and simplifying to make sure funding is more consistent Andy Pow

More practices on the brink

Andy Pow, director at the firm Forvis Mazars, which provides accountancy advice to practices, said he was now seeing more practices in financial trouble than he ever had. Pow, who is a member of the board of the Association of Independent Specialist Medical Accountants, said pressure on income was forcing some practices to make staff redundant or not replace them.

The BMA's guidance on collective action advises practices to "cease all non-contractual work and divert their resources to core services," which can include cutting enhanced services if these are deemed unprofitable.

Bramall-Stainer said the squeeze on discretionary funding was a key factor in GPs' collective action. "It plays its part in why practices are closing and why we are haemorrhaging experienced GPs from the NHS workforce," she said.

Practices were now calculating the costs of providing enhanced services and understanding what gaps they were filling at their own expense, she

WHAT THE BMJ'S INVESTIGATION FOUND

The BMJ asked all 42 ICBs in England under the Freedom of Information Act how much they have spent on discretionary primary care services over the past three financial years and what this represented as a proportion of the ICB's overall budget.

- For 2024-25, 34 ICBs provided comparable data. Of the 34, 27 (79%) either reduced or froze their discretionary spend on primary care services as a proportion of their overall budget when compared with 2023-24: 18 reduced and nine froze. Only seven (21%) increased it.
- For 2023-24, 37 ICBs provided comparable data. Of these, 28 (76%) either reduced or froze discretionary spending when compared with 2022-23: 21 reduced and six froze. Only 10 (27%) increased it.
- Overall, 15 ICBs (44%) reduced or froze discretionary spending as a proportion of their overall budget in both 2023-24 and 2024-25.

DARIA ARTEMENKO / ALAMY

ENHANCED services make up around **10%** of GP income overall, or around **£165 000** for an average sized practice of **10 000** patients, although this varies by local area and by practice, as services are optional

said. "Unfortunately, in many cases, practices may find they are paying to provide these services, and this is why they need to reflect collectively on working with their LMCs around potentially serving notice to the ICB to give their LMC an opportunity to have a reasonable and sensible discussion with the commissioner.

"A large practice delivering a large bundle of services may think, 'We cannot afford to serve notice on this, because we rely on the £100 000 we get for it.' But if they go through it line by line and appreciate it may be costing them £120 000 to deliver, they need to realise what is really happening here and serve the contractual notice."

Huge variation

Bramall-Stainer said it was "striking" how much variability existed in the way funding was distributed and how different pots of money were grouped.

"The inverse care law and postcode lottery are quietly and effectively being played out here," she said. This is why the GP Committee for England was calling for a "sustainable new GP contract" across England to deliver greater health equity, greater value for money to the Treasury, and better financial balance for more practices to stop closures, she added.

The BMJ's data show that, per head of population, ICBs spent £19.85 on average on discretionary primary care services in 2024-25. But there was much variation in both the sums and what ICBs included in their discretionary funding, making direct comparisons difficult.

The lowest payment, at £4.40 a head, was in Shropshire, Telford, and Wrekin ICB. The highest was £54.80, in Somerset ICB. However, the first figure included only enhanced services, while Somerset's included transformation funding and out-of-hours services. On enhanced services alone Somerset's figure was only £15.40.

Calls for a new contract

Pow said the variation in discretionary funding and how it was defined was "problematic" and strengthened the argument for a new contract. "It needs resetting and simplifying . . . to make sure funding is more consistent across the board," he said.

Bramall-Stainer said many of the services highlighted in *The BMJ*'s investigation were needed in every practice across the country so ought to be in the national contract. "People might blithely assume that such basics as phlebotomy services are commissioned in a core contract, but this is not the case," she said.

She said there was still a place for locally commissioned services but that these should be focused on needs relevant to the local population, such as exceptional rurality or demography.

Our members are frustrated that they are having to make difficult decisions
Ruth Rankine

Shifting investment

The Labour government has explicitly said the NHS needs to invest more in primary and community care. Bramall-Stainer said there was an "interesting question" to do with system priorities and cultures. "ICBs have a responsibility to look with a new lens at what they are doing to support the sustainability of general practice services and listen to the new government's priorities around this," she said.

Ruth Rankine, director of primary care at the NHS Confederation, said that GPs and ICBs were being frustrated by pressure to maintain capacity in acute care and to balance budgets, which was leaving "very little bandwidth to start trying to fulfil the government's ambition to move more care closer to home."

She said, "With the pressure on finances, our members are frustrated that they are having to make difficult decisions on the funding and viability of these [enhanced] services.

"Where they are continuing to be commissioned, there is no uplift to the contract value to account for increasing costs, and in many cases services that are reducing demand on other parts of the system are being decommissioned."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2024; 386:q2068

PAULA BRONSTEIN/GETTY

Jordan leprosy free, says WHO

The World Health Organization has officially verified Jordan as the first country in the world to have eliminated leprosy.

Also known as Hansen's disease, leprosy still occurs in more than 120 countries, including Afghanistan (left), with more than 200 000 new cases reported every year, WHO said. Most new cases are reported in Southeast Asia.

Saima Wazed, who heads WHO's global leprosy programme, congratulated Jordan on the milestone. "The fight against leprosy is more than a fight against a disease. It is also a fight against stigma and a fight against psychological and socioeconomic harm."

Jordan has not reported any autochthonous cases of leprosy for more than two decades.

WHO's regional director for the Eastern Mediterranean, Hanan Balkhy, said, "As the first country to achieve this target, Jordan stands as an inspiration to other countries, encouraging them to enhance their efforts and overcome barriers to achieve this remarkable feat."

WHO and Jordan's ministry of health emphasised the importance of maintaining robust surveillance systems to detect and manage future potential cases, without discrimination.

Jacqui Wise, Kent

Cite this as: *BMJ* 2024;386:q2069

Jamela Al-Raiby (left), WHO's Jordan representative, with Feras Ibrahim Hawari, the country's health minister

EDITORIAL

More gun regulation, less firearm harm

US states with tighter restrictions are seeing fewer deaths

As election season heats up in the United States, the issue of gun violence has once again secured a prominent position in American political discourse. This has been intensified by the assassination attempt on former president Donald Trump in Butler, Pennsylvania, and a high profile mass shooting that claimed four lives at a high school in Winder, Georgia.

On one side of the partisan aisle, solutions to the problem have embraced the mantra of "more guns, less crime."[1] Examples of such permissive policies include taking away the discretion of authorities to deny licences to carry concealed firearms, allowing possession of firearms at more locations, and providing increased legal protections to gun owners who use personal weapons in situations where they perceive a threat to self or others. On the other side, solutions have moved towards greater gun control. These restrictive policies include more comprehensive background checks coupled with more rigorous licensing schemes, prohibitions on the availability of certain firearm technologies, and tighter regulation of firearm use and storage as well as firearm possession by high risk individuals.

This divide is an outgrowth of how different US states have been evolving on gun control, especially since the 2012 massacre at Sandy Hook Elementary School in Connecticut. Since then, the US has been setting up something akin to a natural experiment that allows assessment of both approaches to the problem. While 10 years is not a long time, some preliminary results are in—and one side seems to be faring better than the other in terms of reducing suicide, unintentional injury, and intentional interpersonal violence.

JT/STAR MAX/IPX/AP/ALAMY

Gun-free zones are no more dangerous than zones allowing guns, and might even be safer

Louis Klarevas, research professor, Columbia University, New York
ljk2149@tc.columbia.edu

Balance of evidence

Most states in the US have made the acquisition and use of firearms easier. One prominent example is the adoption of "stand your ground" laws, which permit the use of lethal force in self-defence even when it is possible to flee the perceived threat without being physically harmed. Studies have found that these laws are associated with increases in firearm homicide—the outcome they are meant to avoid.[2-4]

Similarly, an argument has been advanced that places where citizens are prohibited from possessing personal firearms are magnets for mass shootings. Research, however, suggests that gun-free zones are no more dangerous than zones allowing guns, and might even be safer.[5] Finally, numerous studies have documented that jurisdictions that make it easier to carry a concealed firearm outside the home tend to experience relatively more violent crime—including homicide, firearm homicide, assault, and robbery—than states that allow authorities to exercise discretion in regulating who can carry guns in public and the conditions under which they may do so.[3-8]

A smaller number of states, accounting for a disproportionately larger relative population, have chosen an alternative approach: enacting stricter regulations on guns and their possession. While many such policy options remain understudied, a sizable and fairly robust literature suggests the success of specific gun control measures. For instance, statewide universal background checks and waiting periods, especially when part of broader permit-to-purchase frameworks—requiring periodic background checks, licence renewals, and, in some instances, fingerprinting, as well as participation in firearm safety training programmes—have been linked to reductions in suicide, homicide, and mass shooting violence.[8-13] Relatedly, public health and safety benefits have been associated with laws that restrict gun possession by young people and by high risk individuals, particularly those with severe mental illness and those with a history of domestic abuse or violent criminality.[4-16]

In terms of reducing mass casualty violence, tight restrictions on access to military style assault weapons and large capacity magazines (devices holding more than 10 rounds) have been associated with lower mass shooting incidence and death rates.[4-19] New evidence suggests that the now expired federal assault weapons ban might have helped reduce firearm injury to youth when it was in effect between 1994 and 2004.[20] Finally, laws governing the safe storage of guns, particularly those preventing child access, have been found to reduce the prevalence of nearly every category of firearm harm.[3-22]

In addition to studies evaluating the effect of individual measures, analyses examining state laws as comprehensive packages have also consistently found that states with more restrictive firearm laws experience significantly less firearm injury and violence than states with more permissive firearm laws.[23-25]

When it comes to firearm regulation and harm, the emerging lesson for policy makers in the US is that more is less. Gun control seems to save lives.

Cite this as: *BMJ* 2024;386:q1984

Find the full version with references at http://dx.doi.org/10.1136/bmj.q1984

EDITORIAL

Citizens' assemblies, health, and health policy

Assemblies can help provide a mandate for bold government action on health

The UK's Labour government inherited a health service with waiting list times at a record high and public satisfaction at a record low.[1] With markers such as life expectancy, child and infant mortality, and avoidable mortality going in the wrong direction, it is unsurprising that voters identified health as a key issue in July's election.[2] Health is more than healthcare—clinical interventions account for only around 20% of health outcomes[3]—and improving the nation's health will require work both within and outside the NHS.[4]

Beyond the NHS, the social, commercial, political, and environmental determinants of health all require urgent attention. There is no shortage of evidence to inform policy options, but practical implementation and prioritisation are too often dictated by short term political interests and perceived public priorities, and governments fail to take the necessary action.[5] So, where should the government begin?

A series of citizens' assemblies on health could provide those in power with the backing for bold and progressive action. Assemblies convene between 50 and 250 participants, selected to represent the broader population with respect to age, gender, ethnicity, social class, and sometimes relevant attitudes. Participants are asked to learn about and deliberate on specific issues and to recommend a set of achievable actions.[6] This process is most useful for decision makers when there is consensus on the need for change but no agreement on the direction it should take.

Demos, a non-partisan think tank, in partnership with the public participation charity Involve, set out a "citizens' white paper" calling for the government to embed public participation in policy making and ensure citizen involvement in

Political buy-in and accountability are essential

Rebecca McKee, senior researcher, Institute for Government, London
Rebecca.McKee@institutefor government.org.uk
Lucinda Hiam, Clarendon scholar, University of Oxford
Bob Klaber, director of strategy, research, innovation, Imperial College Healthcare NHS Trust, London

"policy decisions that affect their lives." Recommendations included setting up citizens' panels to "refine priorities and work through difficult trade-offs,"[7] echoing some of the recommendations on funding in the recent BMJ Commission on the Future of the NHS.[8]

Difficult subjects

Citizens' assemblies can tackle challenging topics and unlock politically difficult decisions. In Ireland, policies on abortion and same sex marriage were informed by citizens' assemblies, ultimately leading to the legalisation of both through referendums.[9] The process has been credited with generating public support for liberalisation and making it easier for politicians to move beyond electoral incentives that had stalled progression.[10] Decision makers in Jersey commissioned a similar exercise as part of their consultation on assisted dying, resulting in the legislature approving plans to legalise assisted dying for terminally ill adults.[11]

During assemblies, participants are invited to consider topics in substantial technical detail. At the climate change assembly in the UK, complex topics such as carbon capture and emission calculations were covered in depth.[12] The resulting recommendations indicated more support for action than many politicians had believed.[13] Citizens' assemblies on the NHS, and health more broadly, might also show that the public's desire for action or change is greater than politicians assume.[14] A Health Foundation poll in August 2024 showed a clear public appetite for a bolder set of government intervention in public health.[15]

Citizens' assemblies are not a panacea. They can be expensive, time consuming processes (although, arguably, policy failure is more costly, particularly when it comes to poor health). One key lesson from the experience of assemblies around the world is that political buy-in and accountability are essential. The process must not be performative. This means governments or other decision makers should commission an assembly with a clear idea of how it will fit into the policy making process and set out a transparent pathway for how the assembly's recommendations will be implemented. The recommendations of the two UK assemblies—climate change in 2020 and adult social care in 2018—were welcomed and fed into the work of parliamentary select committees, but government inaction then stalled any further progress. One model for how this can be done is in Ireland, where assembly recommendations were considered initially by a parliamentary committee before being presented to government. The government then has a duty to respond.

Governments often outsource their advice, in the form of reviews and commissions,[16] returning to familiar experts from previous times in power. But times have changed, and while politicians can learn from the past, they need to look forward to deal with current crises in health. Building public engagement into policy development might just give politicians the public mandate they need to make bold, difficult decisions to improve health.

Cite this as: *BMJ* 2024;386:q1886

Find the full version with references at http://dx.doi.org/10.1136/bmj.q1886

WORKFORCE

The physician associates becoming doctors

Former PAs who have moved into medicine speak to **Erin Dean** about the realities of their former role

LANKOWSKY/ALAMY

After completing her physician associate (PA) course, Caitlin Callan secured a job on a busy medical ward in a district general hospital—and loved it. "The hospital was good, and I felt part of and well supported by the ward staff," she says. "I worked in a team with the junior doctors, following the consultant, doing some of the jobs alongside them. I did enjoy it initially. But I wanted more. I wanted to progress."

After a year she realised that being a PA probably wasn't the right role for her because of the lack of opportunities to advance. She looked into medicine and has just completed her first year at medical school. Callan is one of a small group who have made the switch from being a PA into medicine, giving them a unique insight into a role that's become bitterly divisive among doctors.

PAs are healthcare professionals who work as part of a multidisciplinary team with supervision from a named senior doctor, according to the Foundation of Physician Associates. They complete a two year postgraduate course to work in what's described as a "medical model."

Some doctors have major concerns about the role, including the ongoing lack of regulation, the absence of a scope of practice, and the worry that PA training may take time and opportunity away from training doctors. But other doctors remain supportive of a role that's helped them manage crushing workloads.

However, only a small number of professionals have experienced life both as a PA and as a doctor or medical student.

Why switch?

The reasons given by former PAs for changing to medicine include the limitations and lack of progression in their role, concerns about how they were used in practice, and the reignition of a previous desire to be a doctor. But there's also a recurring theme around safety, with some former PAs expressing concern that their depth of knowledge was insufficient for the tasks they were required to undertake.

This taps into concerns held by many doctors about the PA role, while NHS England plans to expand the PA workforce to 10 000 by 2036-37. Around 3240 PAs were on the voluntary register in October 2022, the most recent figure available.

For Callan, the PA course she attended—which has since closed—didn't feel well organised. "There weren't many lecturers, and we weren't well prepared to work in a hospital," she says. "I wanted to have the knowledge to be a safe clinician, but I don't feel as though I necessarily got taught enough at university. There was a lot of learning on the job."

This is what also prompted Dru Lawson-Short to apply to medical school in the second year of his PA course. He completed the course but never worked as a PA, moving almost straight onto a four year graduate entry medical course at Birmingham University.

"The reason I didn't want to work as a PA is that I didn't feel safe to do so," says Lawson-Short, who is coming to the end of his first foundation year. "I knew there were gaps in my knowledge, but I wasn't aware of where they were and how deep. While I have gaps in my knowledge now as a doctor, I'm much more acutely aware of them.

They have a unique insight into a role that's become bitterly divisive

"I did feel when I came to the end of my medical degree that I was safe and ready to practise as an FY1. As a PA, as there was still so much uncertainty about what that role would be and what it would entail, I didn't feel safe practising."

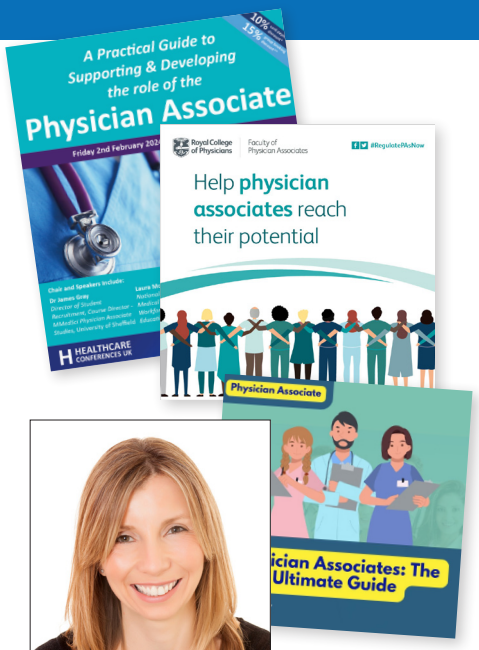
Concerns

Lawson-Short says that he and his fellow PA students received 15 days' education on each of the hospital specialties. "Then to go and work in, say, paediatrics and be assessing acutely unwell children—that's an incredible ask from somebody who only has that level of training," he says.

He felt more confident about working in general practice towards the end of his PA course than he does now, and he believes that this is a worrying reflection. "I was overconfident about the level of knowledge that I had," he says.

The ongoing lack of a clearly defined scope of practice has worried some former PAs, including Lawson-Short. "PAs can be useful in the workforce, but the role has been expanded too far beyond what it was initially," he says. "Some of that has come at the expense of doctors and patients."

Donya Mighty, who recently graduated from Warwick Medical School, qualified as a PA in 2018 and has continued to work in the role to support herself financially through



the graduate entry medicine course. She's seen the PA role change and expand quite significantly since she started her training in 2016.

"I've heard instances of PAs working on registrar rotas where they're providing specialist clinical advice to other specialties and performing solo surgeries," says Mighty. "That just sounds crazy to me, because I would think that's well beyond what the scope of the PA is. But the problem is that scope has never been completely defined."

She says that, while she's loved being a PA and has mainly worked with supportive medical colleagues, she can understand why some doctors are concerned. In general practice, for example, she worries that supervision can vary between practices, raising the risk of safety errors. "I insisted that I discuss [with a GP] every single patient I'd seen, because I believed that was the appropriate level of supervision," she says. "Due to time constraints and other factors, I don't think that discussing every patient the PA has seen happens across the board."

PA training—not for failed doctors

Some of the PAs who spoke to *The BMJ* had turned to the role after failing to get into medical school. Statistics published as part of a freedom of information request to the Universities and Colleges Admissions Service and shared online suggest that this scenario isn't unusual, as more than half of applicants to PA courses in 2022 and 2023 had applied for medicine in the previous three years.

Supervision can vary between practices, raising the risk of errors

Lawson-Short says that would-be doctors are probably not the best fit for the PA role. "The PAs that I knew who had never applied for medical school, who had no intention of actually being doctors, have turned out to be the greatest assets to their teams," he says. "They don't have chips on their shoulders and don't have any designs on medicine."

For one former PA student, who had planned to train in the US and then chose to study in London, part of the problem was the notable proportion of her peers who had wanted to be doctors. "In the US, those who are taking the PA course are staunchly PA students and you don't often have people applying to medical and PA school," she says. "The US requirement for extensive prior clinical experience is a significant differentiator for PA applicants. In the UK this is absent, allowing for the PA role to be seen as a plan B to medicine."

She left her PA course after a year. "I struggle to see how you can be committed to the PA role when that wasn't ultimately what you wanted to do," she adds.

Jeannie Watkins, PA studies programme director at Swansea University and immediate past chair of the PA Schools Council, agrees that professional identity has been challenging for PAs. "Those who wish to be doctors should pursue medicine," she says. "PAs are not doctors, and it should not be a second choice or default for those who didn't get into a medical programme, as those who come onto programmes struggle with the limitations of the role and want more." This was echoed by some people who spoke to *The BMJ*, who found that their ambitions were restricted by the role.

PA programmes work hard to recruit people who are the right fit, says Watkins. She adds, "The profession is working hard to ensure there is clarity about professional identity, roles, and responsibilities."

Scapegoats

Some former PAs emphasised the positive learnings from their experience. Adam Calthrop, now a medical student in the Midlands, trained and worked for four years as a PA in emergency medicine and primary care in Berkshire and reflects positively on his excellent PA training. Being on placement for 40 hours a week, although tiring, led to learning in a traditional firm model, he says, allowing for professional relationships and apprenticeship-style learning.

"Modern day medical school is very fragmented," says Calthrop. "As a student I'm sometimes only on the wards one day a week, with a lot of my time spent in scheduled teaching. As a PA student I was always based in one area for six weeks.

"I got to know the doctors and built up a good relationship, helping them with lower skill repetitive tasks, in exchange for teaching. I feel very fortunate to have learnt so much from a fantastic team and had access to appropriate supervision."

But the former PAs have strong sympathy for the current PA workforce, who find themselves in an increasingly difficult situation with an uncertain future. And Callan says that PAs have been scapegoated for issues they play no part in, such as doctors being underpaid.

Mighty concludes, "I really do see it from both sides—there are no winners out of this. I feel for my PA colleagues who have had an incredibly difficult time over the last 18 months or so, many of them facing hostility in the workplace. And I also really feel for medical colleagues, who are feeling devalued and seeing the expansion of this other role that has less training, better working conditions, and better pay."

Adam Calthrop, a former PA now medical student, and Jeannie Watkins, PA studies programme director at Swansea University

Erin Dean, freelance health journalist, UK
erin@erindeanwriting.com

Cite this as: *BMJ* 2024;386:q1989

INQUESTS

What can we learn from coroners' reports on preventable deaths?

Campaigners say the lack of response to official warnings after a death is a missed opportunity to improve patient safety. But there are signs that systemic issues are gaining recognition, reports **Samir Jeraj**

ROWENA SHEEHAN

Last year, coroners opened 36 900 inquests into deaths in England and Wales. They included some of the most traumatic and sensitive deaths in these countries: deaths in state detention, deaths of children, suicides, and drug related fatalities.

Of these deaths, 569 were deemed to have been avoidable by the coroners examining them, compelling them to set out how such deaths could be prevented in the future. However, there's little evidence that these recommendations are being listened to.

Coroners in the UK have been able to issue prevention of future deaths reports (PFDRs) since 2013, as part of reforms introduced by the Coroners and Justice Act 2009. The reports enable coroners to raise any matters of concern if this may prevent future deaths. At the time of publication, 5268 such reports have been published. This September, one such report warned that a common practice used by anaesthetists could lead to deaths, after concluding that a woman had died because she received too large a dose of a local anaesthetic during an operation.

However, there's a growing body of opinion and evidence that the report system isn't working as it should. "The really important question, that no one is asking, is what is the effectiveness of PFDRs in saving lives?" says Georgia Richards, teaching fellow in evidence based medicine at Oxford University and founder of the Preventable Deaths Tracker (see box overleaf). She developed the tracker during her PhD to research deaths attributed to opioids.

"Completely pointless"

"The one thing that [bereaved families] hope to get, that often means the most to them, is that something will change," says Marienna Pope-Weidemann. The death of her cousin Gaia Pope-Sutherland was the subject of a PFDR in 2022. No fewer than nine agencies were required to respond to the report, including the police, the local NHS trust, the local council, and the College of Policing.

The response from the College of Policing was that the coroner's recommendation for police officers to be better trained on mental health was "not practical," and the Royal College of Psychiatrists responded that there was "currently no funding" to establish a GMC credit for neuropsychiatry.

Pope-Weidemann is now working on a book about people who have died as a result of state action. She says it's beyond belief that there isn't even a basic oversight mechanism that keeps a list of recommendations from PFDRs. She tells *The BMJ*, "All the bereaved relatives I've ever spoken to, without exception, from the past seven years, all feel that PFDRs are completely pointless."

On top of this is the very real pain that bereaved families go through when another similar death occurs. Pope-Weidemann explains, "I think it's like the bereaved relative equivalent of how we talk about survivor guilt."

Liridon Saliuka, 29, died by suicide in HM Prison Belmarsh in January 2020 after being moved from a cell that was adapted to his disabilities to one that was not, despite his explicit objections. The PFDR issued by the coroner in November 2022 highlighted

ROD MINCHIN/PA/ALAMY

The families of Gaia Pope-Sutherland (left) and Liridon Saliuka (above) are fighting for changes to official practices after their deaths

a lack of disability awareness at HMP Belmarsh and the absence of documentation detailing the adjustments Saliuka needed. HM Prison and Probation Service responded in January 2023, saying that it would hold monthly staff training sessions at HMP Belmarsh about disability.

However, the Oxleas NHS Foundation Trust, which was also named in the report, has yet to have its response published. Dita Saliuka, Liridon's sister, has received the PFDR response from the trust but doesn't believe that anything has changed. Nor does she believe that things have improved at HMP Belmarsh now that its healthcare is being provided by a different company.

Norfolk and Suffolk NHS Foundation Trust recently published a review of all deaths in the trust from 2019 to 2023, to examine the trust's "previous inability to fully review the deaths of patients" during that time. One of the review's three areas of focus is learning from all published PFDRs, which named the trust 14 times in those four years (and six more before that), and improving services to help prevent deaths in the future.

The inability of the coroner system to enforce its findings means that families end up carrying the responsibility and burden in pushing for change and action. One such campaign is "Ella's law"—establishing the right to clean air—led by Rosamund Adoo-Kissi-Debrah, whose daughter Ella's death was the first in the UK to be recorded as resulting from air pollution.

Rosamund initially had to campaign for the first inquest into Ella's death to be overturned before the verdict of death by air pollution could be accepted. While she believes the coroner did a "pretty good job" of what went into the PFDR, action by the 14 agencies named in the report has been lacking.

A lack of follow-up—and teeth

Information collected by Richards's Preventable Deaths Tracker shows that in the past 10 years just over 40% (2040) of PFDRs were related to hospital deaths that had resulted from clinical procedures or medical mismanagement. And while any organisation named in a PFDR has 56 days to respond under the law, there's no sanction if it fails to do so. Nor is there any mechanism to follow up on whether recommended changes to policy and practice have been made.

Some NHS trusts have a formal system to respond to PFDRs and learn from them, as well as looking at PFDRs sent to other trusts to see if there are lessons to learn from those cases. But some trusts have nothing, leading to a piecemeal system where change is haphazard.

There's also a lack of clarity as to when coroners should be issuing PFDRs—and to whom. In one case reported to Inquest, a charity that advises on state related deaths, a PFDR was issued after the death of a young woman in a mental health facility run by a private company. The PFDR was issued to the manufacturers of the anti-ligature clothing that had contributed to her death, but no PFDR was issued to the healthcare provider.

Later, the healthcare regulator the Care Quality Commission (CQC) reported on the unit as part of an inspection. It found that a lot of the issues that had been raised at the inquest still hadn't been dealt with, and the CQC rated the unit inadequate. Had the chance been taken to issue a PFDR to the unit, Inquest says, those issues could perhaps have been tackled sooner and safety improved.

The Office of the Chief Coroner declined to comment on this issue but instead referred to statements previously made by the chief coroner, that the role of coroner ends once a PFDR is issued and that the coroner's office is not a regulator.

More than a paper exercise?

The prevention of future deaths (PFD) system is now attracting attention, partly owing to its perceived failures and underperformance but also because of its potential to be a better source of data to improve safety. In October 2023 the Independent Advisory Panel on Deaths in Custody—a non-departmental

Rosamund Adoo-Kissi-Debrah led the campaign for the death of her daughter Ella to be recorded as "death by air pollution"

HOLLIE ADAMS/AFP/GETTY IMAGES

public body that aims to reduce such deaths—published *More than a Paper Exercise*, an investigation of PFDRs.

The authors found routine problems with the PFD reporting system, including omission of key information in the final reports, inclusion of factual errors in some cases, and a failure by coroners to follow the guidance issued by the chief coroner. They recommended that the Office of the Chief Coroner be better resourced to review PFDRs annually and to record the conclusions of inquest juries even where no PFDR was published.

PFDRs should be shared across relevant sectors, the authors wrote, and the Department of Health and Social Care should give "serious consideration" to creating an independent body to investigate deaths of people under detention in mental health settings.

Soon after the Independent Advisory Panel on Deaths in Custody's report was published, the parliamentary Justice Committee launched an inquiry last November into the coroner service, including the PFDR system. The inquiry aimed to improve the service and revisit recommendations made in 2021 to improve it.

The lack of a mechanism to compel a response from organisations named in PFDRs was one of the main discussion points at the hearings. The committee said in its report that the absence of follow-up to coroners' reports was a "missed opportunity." It added, "The Ministry of Justice should consider setting up an independent office to report on emerging issues raised by coroners and juries."

Lacking oversight

There are examples of how the practice of using PFDRs is changing and improving. Some coroners are now starting to reference previous PFDRs in their own reports, to highlight where deaths have a common factor and to lend weight to the case for change. Others are starting to issue a PFDR before an inquest so that it acts as an early warning on a particular issue.

PREVENTABLE DEATHS—IN NUMBERS

An average of 463 prevention of future deaths reports (PFDRs) have been published each year for the past 10 years, according to the Preventable Deaths Tracker, a website and newsletter run by the academic Georgia Richards. In 2023, 544 were published, 115 of which related to suicides, the highest number since the category was introduced in 2015.

The UK Office for National Statistics carried out its own analysis in March 2023 of PFDRs on suicide and highlighted the commonest factors: poor processes, poor staffing, and problems in getting access to services. While most of the cases involved NHS organisations, reports were regularly issued to government departments, professional bodies, the prison service, and the police.

A striking geographical variation is seen across the 82 coroner areas of England and Wales: Greater Manchester South has issued the most PFDRs (410), followed by London Inner North (210), while Northumberland South and Ceredigion have issued just a single PFDR each since 2013.

Just over two fifths (44%) of PFDRs issued in the past 10 years have received responses from the organisations they name, but 25% of responses remain outstanding, and a further 12% have had only a partial response. Of the remaining reports, 2% are still within the 56 day response period and 17% have no data on who the respondents were.

But a lack of oversight and cooperation has been seen as a problem. The charity Inquest has been campaigning for an independent oversight mechanism, separate from the coroner system, that would carry out analyses of PFDRs at a national level.

"Prevention of future deaths reports have an important preventive role: they can help facilitate improvements in policy and practice to save lives," says Inquest's policy and parliamentary manager, Rosanna Ellul. "However, in the absence of a proper oversight system, it is far too easy for the recipients of reports to dismiss the concerns made . . . with coroners repeatedly raising the same concerns about failures in individuals' care."

The Office of the Parliamentary and Health Service Ombudsman said that it could not provide comment on cases it hadn't investigated, but it highlighted its own 2023 report *Broken Trust*, which concluded that "the NHS must do more to accept accountability and learn from mistakes, particularly when there is serious harm or, worse, loss of life." The report recommended strengthening oversight of trusts, reviewing oversight arrangements, and publication of the delayed NHS workforce strategy.

A spokesperson for the Department of Health and Social Care said, "Every preventable death is a tragedy, and our thoughts are with families and friends who have lost loved ones." They added that PFDRs provided "valuable insight by highlighting issues where more action could be taken." The spokesperson said that the department responded to and learnt from each PFDR and that it engaged with NHS England, health regulatory bodies, and other organisations when responding.

NHS England has told *The BMJ* that PFDRs that are addressed or contributed to by NHS England, and their responses, are held centrally for "monitoring and review" and are discussed by regional medical directors to ensure that "key learnings and insights around preventable deaths" are shared across the NHS.

But Richards would like the UK to follow the example of Australia and New Zealand's National Coronial Information System, a database of information collected through the coronial system about deaths and used in real time across government. "It's used on a daily basis in policy making," she says. "It's used by the departments of transport, education, healthcare, and housing. There are so many different departments that use that database: it changes policy, changes practice, and saves lives."

By contrast, the UK system is highly adversarial, with organisations seeking to avoid being named in PFDRs and some law firms advertising their ability to keep names out of reports as a service.

Pope-Weidemann believes that reform should go further than an oversight mechanism, particularly where multiple PFDRs are sounding the alarm on the same issue, with real accountability when recommendations are not implemented. "The only people who ever, ever, ever even try to push that forward are the families," she says. "How grossly inefficient and unfair and absurd is it that it falls on our shoulders?"

No one is asking what is the effectiveness of PFDRs in saving lives? Georgia Richards

It is far too easy for the recipients of reports to dismiss the concerns Rosanna Ellul

Samir Jeraj, freelance journalist, London
sa.jeraj@gmail.com
Cite this as: *BMJ* 2024;386:q1943