NEWS

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Older mothers in good health still have higher chance of birth complications

Hunt announces drive to clear 12 month waiting list

ASHLEY PRYTHERCH OF THE ROYAL SURREY COUNTY HOSPITAL

Jeremy Hunt: managers gamed the system to meet the 18 week target–at the expense of some patients

Caroline White LONDON

The health secretary, Jeremy Hunt, has told NHS hospitals in England to clear their "unacceptable" backlog of patients who have been waiting more than 12 months for treatment, even if this means breaching the 18 week referral to treatment target for other patients.

In a speech to staff at the Royal Surrey County Hospital in Guildford on 4 August, the health secretary said that it was "unacceptable" for patients who were in pain or discomfort to wait a long time for their treatment.[1] "No one should have to wait more than a year for treatment" without good reason, he said, adding that he wanted the numbers to be "as close to zero as possible."

As of May 2014 some 574 people had been waiting at least 12 months for their treatment, and 193 807 had been waiting for more than 18 weeks. In 2010 the equivalent figures were 18 458 and 209 411, respectively. Hunt said that NHS England would review all 574 of the 12 month plus cases to ensure that those patients were treated as quickly as possible.

In June of this year the government pledged £250m to help trusts clear their backlog of elective surgery cases, and the health secretary explained that he had asked NHS England to commission 100 000 extra treatments over the summer, including 40 000 additional inpatient admissions. He admitted that the focus on the "long waiters" might mean that "we undershoot the 18 week target for a temporary period," but he promised that this would be back on track by the end of the year.

Focusing now on getting the "short waiters" through the system would amount to "an indefensible betrayal of those who have been waiting the longest, and not one that I would be prepared to sanction as health secretary," he declared.

He explained that the 18 week target, introduced by the previous Labour government in 2007, had incentivised healthcare managers to play the system to boost their performance figures, by focusing on patients who had not yet missed the target—at the expense of those who already had. "Under huge political pressure, managers inevitably gamed the system to make their organisation look good—and patients suffered the consequences," said Hunt, but he added that he had no intention of abolishing targets; rather, he wanted them implemented "more humanely and sensibly."

But Hunt's speech failed to impress doctors' leaders. The government was, "in effect, having to ration care," commented Mark Porter, chair of the BMA Council. "This is yet more evidence that the NHS is buckling under extreme pressure and that patient care is being compromised," he said.

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Daily aspirin reduces risk of developing and dying from cancer, researchers find

Ingrid Torjesen LONDON

Taking aspirin daily can dramatically reduce the risk of developing and dying from cancer, especially from tumours of the gastrointestinal tract, researchers from Queen Mary University of London have found.

To reap the benefits, said the study, patients needed to take a 75-100 mg daily dose for at least five years, and preferably for 10 years, between the ages of 50 and 65. No benefit was seen while taking aspirin for the first three years. Death rates reduced only after five years, and most of the benefits were seen after patients had taken aspirin over a prolonged period and then stopped.

The researchers collated the most recent systematic reviews of the effect of aspirin on the incidence of and mortality from specific cancers and cardiovascular events. They also quantified the harms from taking aspirin in terms of the incidence of and mortality from gastrointestinal bleeding, peptic ulcers, and strokes.

The results, published in the *Annals of Oncology*,[1] showed that aspirin could reduce incidence of colorectal cancer by 35% and its mortality by 40%. In oesophageal cancer, incidence was reduced by 30% and mortality by 50%, and in gastric cancer these decreased by 30% and 35%, respectively. The study also found a smaller effect on cancers of the lung, prostate, and breast.

The study also showed that aspirin had a preventive effect on myocardial infarction: it reduced incidence by 18% and mortality by 5%. The effect of aspirin on strokes was more complex: its use adversely affected haemorrhagic strokes but was beneficial for ischaemic strokes.

The researchers modelled the effect of everyone aged 50 to 64 in the United Kingdom taking aspirin for 10 years and found that over 20 years it would save 121 902 lives. There would be 130 357 fewer cancer deaths, 9473 fewer deaths from myocardial infarction, but 17 923 more deaths from stroke.

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IN BRIEF

Slight drop recorded in 999 calls for an ambulance: In 2013-14 8.47 million emergency 999 calls were made for an ambulance, figures from the Health and Social Care Information Centre have shown—an average of 16.1 a minute or 23 216 a day. Ambulance services also receive emergency calls via the 111 service. Emergency vehicles responded to 6.33 million calls last year, of which 95.1% (6.02 million) were to a 999 emergency call and 4.9% (309 260) were to a 111 call.

French hospital plans to open wine bar for terminally ill patients: Clermont-Ferrand University Hospital in Puy-de-Dôme in central France is to open a wine bar in its palliative care centre so that patients can have a drink with relatives and friends. The head of the centre, Virginie Guastella, told the news agency Agence France-Presse that the bar would "cheer up the difficult day to day existence of patients" and would allow families facing bereavement to "create moments of conviviality" despite being in a hospital environment. In addition to wine, the bar will serve beer, whisky, and champagne.

Earlier screening is recommended for Edward's syndrome and Patau syndrome: The UK National Screening Committee has recommended bringing forward screening tests for Edward's syndrome and Patau syndrome, also known as Trisomy 18 and Trisomy 13. These rare but serious abnormalities can be detected through a scan, which is offered to all women in England between 18 and 20 weeks of pregnancy. However, combining a blood test and scan during the first trimester could identify heightened risk of the conditions and enable women to make important choices at an earlier stage, the committee said.[1]

Another doctor dies from Ebola and an infected US doctor is flown home: Sheik Umar Khan, a leading Ebola doctor in Sierra Leone, has died from the disease, bringing the number of doctors who have died from Ebola to three in the space of a month.[2] Kent Brantly, a doctor from Fort Worth in Texas, has been flown back to the US and is being treated at a special unit at Emory University Hospital in Atlanta, Georgia. At least 60 of the 729 deaths so far in the 2014 outbreak have been among healthcare workers.

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Primary care telephone triage does not reduce workload, study finds

Susan Mayor LONDON

Primary care telephone triage, where a GP or nurse calls a patient who has requested a same day consultation, does not reduce overall practice workload, a large pilot study in England has found.[1] The study showed that this approach actually increased the number of primary care contacts compared with initial face to face consultations.

Many practices have introduced telephone triage to try to cope with the growing demand for consultations. Patients requesting a consultation are called back by a doctor or nurse, who either manages their problem on the phone or determines how urgently they need to be seen in the practice.

Until now limited evidence has supported this approach. To find out more, researchers randomised 42 practices in four centres across England to either GP led triage, nurse led triage with computer support, or usual care, in which a patient has a face to face consultation. They studied 20 990 patients initially asking for same day but not emergency appointments, with complete information available for 16 211 (77%).

The results showed that GP triage was associated with a 33% increase in the mean number of contacts per patient in the 28 days after the initial request for a consultation compared with usual care (2.65 *v* 1.91 contacts, rate ratio 1.33 (95% confidence interval 1.30 to 1.36)). Contacts with patients undergoing nurse triage increased by 48%, with a mean of 2.81 contacts (1.48 (1.44 to 1.52)). Despite the increase in number of contacts with telephone triage, the estimated costs were similar across all three groups, at around £75 per patient.

The lead author was John Campbell, professor of general practice and primary care at the University of Exeter Medical School. He said, "Up to now, it has been widely thought that introducing a triage system might be an efficient way of providing same day access to healthcare advice. However, our study suggests that introducing triage may not represent the most efficient use of doctor or nurse time."

MARK THOMAS/SPL

Patients who get telephone support are more likely to seek follow-up advice, said author John Campbell

The study showed that introducing telephone triage resulted in a redistribution of GP workloads away from face to face consultations and towards more telephone consultations or nurse led care. GPs working in practices that operated GP triage had 39% fewer face to face consultations, while those in practices with nurse triage had 16% fewer.

"Patients who receive over the phone support are more likely to seek follow-up advice, meaning that the workload is only redistributed, whilst the costs are the same," Campbell concluded.

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Whistleblowers are treated "shockingly"

Clare Dyer THE BMJ

Whistleblowers in public services, including the NHS, have been subjected to "shocking" treatment, and government departments have failed to protect them from being victimised, an influential committee of MPs has said.

The House of Commons Public Accounts Committee said that it had heard of too many cases where colleagues meted out "appalling" treatment to co-workers who had blown the whistle on wrongdoing, but departments had been unable to tell the MPs whether victimisers had been sanctioned.

In its evidence to the committee the whistleblowing advice charity Public Concern at Work could recall only one case in which an employee who victimised a whistleblower had been sanctioned. The MPs recommend in their report, published on 1 August, that departments ensure that a board member is responsible for whistleblowers; that they provide legal and counselling services to employees who blow the whistle; and that they put in place appropriate and swift sanctions against employees at all levels who victimise whistleblowers.[1]

The committee took evidence from four departments, including the Department of Health for England; from Public Concern at Work; and from Kay Sheldon, a whistleblowing board member of the Care Quality Commission (CQC).

Sheldon told the MPs that Jo Williams, former chair of the CQC, had written to Andrew Lansley, then health secretary, to ask for Sheldon's removal from the board. She said Lansley had appointed a review that was a "hatchet job" and told her that she may have met the statutory requirements for removal. Sheldon got legal advice that the review was unfair and unlawful

Minimum unit price on alcohol would affect heavy drinkers 200 times more than moderate drinkers

Adrian O'Dowd LONDON

A minimum unit price for alcohol would affect harmful drinkers 200 times more than low risk drinkers, a new study has concluded.

The study[1]—published in *Clinical Medicine*, the peer review journal for the Royal College of Physicians—said that a minimum unit pricing policy for alcohol was "exquisitely targeted" at the heaviest drinkers with cirrhosis. Researchers from the University of Southampton studied the amount and type of alcohol drunk by 404 patients with a range of liver disease in a large teaching hospital and asked the patients how much they paid for alcohol.

They found that patients with alcohol related cirrhosis drank on average the equivalent of four bottles of vodka each week and bought the cheapest alcohol that they could find—paying around 33p per unit, irrespective of their income. In contrast, low risk moderate drinkers were paying on average £1.10 per unit.

Over the past 30 years the UK has seen a fourfold increase in deaths from liver disease, as alcohol has become less expensive and more easily available. Reducing its affordability is recognised internationally as an effective and cost effective means of reducing alcohol related harm, but the idea of setting a minimum price per unit has proved controversial.

In July last year the government abandoned plans[2] to introduce a minimum price for a unit of alcohol in England, citing insufficient "concrete evidence" that such a move would work. But in Wales a minimum alcohol price of 50p per unit could become law as part of a public health bill for Wales planned for early next year. Plans by the Scottish Government to set a 50p rate per unit of alcohol could be delayed by two years after a legal challenge by the Scotch Whisky Association.

MICHAEL WALTER/PA

"An almost perfect policy," said one of the study's authors of a minimum unit price for alcohol

The authors of the new study said that if the government were to set a minimum unit price of 50p it would not affect pubs or bars and would have only a minimal effect on moderate drinkers: the average cost would be £4 per year, and 90% of such drinkers would not be affected at all. The impact on heavy drinking patients with liver damage, however, would be at least 200 times higher, the study found.

Nick Sheron, of the University of Southampton's faculty of medicine, said, "Setting a minimum unit price for alcohol is an almost perfect alcohol policy because it targets cheap booze bought by very heavy drinkers and leaves moderate drinkers completely unaffected.

"When the government says it is concerned about the impact of MUP [minimum unit pricing] on moderate drinkers, [it is] simply repeating propaganda which has been put out by the drinks industry."

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MARTIN POPE/THE DAILY TELEGRAPH

Kay Sheldon kept her job at the CQC after agreeing not to take legal action against Andrew Lansley

and reached an agreement with Lansley that she would not take legal action against him if she was allowed to remain on the board.

The MPs found a "startling disconnect between the generally good quality of whistleblowing policies in theory and how arrangements actually work in practice." Employees continue to lack trust in the system and have "often justified" fears of reprisals if they report serious wrongdoing.

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GP antibiotic prescribing rose by 40% in 12 years

Caroline White LONDON

The likelihood of GPs prescribing antibiotics for coughs and colds rose by 40% from 1999 to 2011, despite a push by the government to reduce the amount of antibiotics prescribed for viral illnesses, a study in the *Journal of Antimicrobial Chemotherapy* has shown.[1]

The highest prescribing practices were twice as likely to hand over a prescription for coughs and colds as the lowest prescribers, the findings showed. The researchers, from Public Health England and University College London, concluded that GPs needed to improve their antibiotic prescribing patterns.

Specific recommendations on better prescribing by GPs were first made by the Department of Health in 1998,[2] and they have since been regularly updated by Public Health England and endorsed by the Royal College of General Practitioners. They advise no prescribing of antibiotics for simple coughs and colds or for viral sore throats and recommend restricting a course of antibiotics for uncomplicated cystitis to three days.

The researchers monitored prescribing patterns at 537 UK general practices from 1995 to 2011 to find out how well they were following national treatment guidelines. They found that the proportion of patients who were prescribed an antibiotic for coughs and colds fell from 47% to 36% from 1995 to 1997 but then rose again to 51% by 2011.

Antibiotic prescribing for sore throats also fell, from 77% in 1995 to 62% in 1999, after which it stabilised. But the 2011 data showed that over 30% of patients who were prescribed antibiotics for sore throats had received one that was not recommended in guidance.

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Wendy Savage
Committed and compassionate

PETER LOCKE

WENDY SAVAGE, a staunch advocate of women's rights in fertility, abortion, and childbirth, was an obstetrician and gynaecologist who in 1985 was the victim of a miscarriage of justice. Suspended from the London Hospital Medical College after allegations of incompetence, she won her job back after a high profile inquiry found the charges groundless. She served for many years on the General Medical Council and is president of Keep Our NHS Public, a pressure group that opposes private contractors providing NHS care. She has also been press officer at Doctors for a Woman's Choice on Abortion since 1977.

What single unheralded change has made the most difference in your field in your lifetime?
"Politically, the 1967 Abortion Act, which virtually eliminated deaths from unsafe abortions in Great Britain. Socially, the oral contraceptive pill, which gave women Dugald Baird's "fifth freedom," from unwanted pregnancy"

What was your earliest ambition?
When I was 14 I moved to a bigger school and started sciences. I loved chemistry, and I thought I would be a research chemist.

Who has been your biggest inspiration?
I'm not sure that I have ever been inspired. After my first year at Cambridge, when I saw what chemists did, I woke up one morning and decided to be a doctor. As a student, Donald Hunter impressed me with his passion for industrial medicine. Two excellent role models were Angelo Caroli, who taught me surgery in Awo-Amamma in eastern Nigeria, and Valerie Thompson—the first woman senior registrar at the London Hospital in obstetrics and gynaecology, and later my consultant at the Royal Free Hospital—who introduced me to psychosexual medicine.

What was the worst mistake in your career?
Not realising that the person who was supposed to be arranging for me to go to the US, to work in a service for poor women in East Boston, couldn't do it. I couldn't get a visa in time and so had to remain in the UK.

What was your best career move?
Accepting the lecturer post with Peter Huntingford in 1976 at the London Hospital.

Who is the person you would most like to thank, and why?
My ex-husband, for fathering four beautiful children and taking us around the world.

To whom would you most like to apologise?
Those patients, or their babies, who suffered because of my ignorance or inexperience.

Bevan or Lansley? Who's been the best and the worst health secretary in your lifetime?
Bevan was the best, with Frank Dobson second for honouring the election pledge to get rid of fund holding. He would have got rid of Kenneth Clarke's purchaser/provider split too, if he had not been pushed out. Worst was Lansley, with Clarke close behind for introducing the internal market. Clarke also designed the private finance initiative (PFI).

If you were given £1m what would you spend it on?
I would give half to Abortion Rights and half to Keep Our NHS Public, to support their campaigns for women's abortion rights and the fight against NHS privatisation.

Where are or were you happiest?
Walking in the Howgill Fells on a clear day.

What single unheralded change has made the most difference in your field in your lifetime?
Politically, the 1967 Abortion Act, which virtually eliminated deaths from unsafe abortions in Great Britain. Socially, the oral contraceptive pill, which gave women Dugald Baird's "fifth freedom," from unwanted pregnancy. And in obstetrics, ultrasound, which is a mixed blessing.

Do you believe in doctor assisted suicide?
I believe that people should have the right to end their lives in a painless and dignified way. I support the attempts to change the law to allow doctor assisted suicide, but, having accompanied a friend to Switzerland to die, I do not see the need for a doctor to participate in the final act—although doctors have a role in assessing mental competence and state of mind.

What book should every doctor read?
The Spirit Level: Why More Equal Societies Almost Always Do Better by Wilkinson and Pickett, which demonstrates the effects of income inequality on health and society.

What poem, song, or passage of prose would you like mourners at your funeral to hear?
Possibly "Summertime" from *Porgy and Bess*, which my mother used to sing to us as children.

What is your guiltiest pleasure?
I don't associate guilt with pleasure.

If you could be invisible for a day what would you do?
Sit in on a cabinet meeting when they were discussing health.

What is your most treasured possession?
My grand piano, although I don't play much these days.

What personal ambition do you still have?
I want the law to be changed so that abortion performed by qualified health professionals is not a criminal offence.

Summarise your personality in three words
Hardworking, committed, and compassionate.

Where does alcohol fit into your life?
I enjoy an evening gin and tonic or wine with friends, and I try to keep below three units per day.

What would be on the menu for your last supper?
Garlic prawns; roast lamb with roast potatoes, broad beans, and peas; and rhubarb crumble with cream.

Do you have any regrets about becoming a doctor?
No, I think it is a fantastic job.

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