ELECTION WATCH Gareth Iacobucci

Promises, promises—and common ground

ELECTION 2015

How did the party health spokespeople fare when they faced a grilling from health service professionals at the British Library in London on Tuesday? **Gareth Iacobucci** reports from an NHS focused general election hustings

During the 90 minute session the politicians faced questions from the floor on a range of key healthcare issues, including funding, competition, staffing, and pay. They were also pressed on the future of mental health and general practice and asked how they would pursue the new models of care proposed in NHS England's *Five Year Forward View*.

SARAH TURTON

Health spokespeople face the music

Funding pledges

The parlous state of NHS finances infused much of the discussion. The participants clashed over their respective funding commitments, discussed in last week's Election Watch (*BMJ* 2015;350:h2009). The NHS Confederation's chief executive, Rob Webster, asked all the panellists whether they were confident that the amount of money they had pledged for the NHS was enough to meet their expectations on quality of care.

Jeremy Hunt: "We took the £8bn [€11bn; $12bn] figure from the NHS's own plan—the *Five Year Forward View*—which said there would be about £22bn of efficiency savings. The funding is coming on the back of having the strongest economy in the G7."

Andy Burnham: "The money we have pledged [£2.5bn] will go in this year and next year, because the crisis is now . . . At the moment, we're spending thousands on keeping people unnecessarily in hospital. We have to have financial reform that gives the NHS incentives to support people in their own homes. But then you have to add more [money] in."

Norman Lamb: "The Lib Dems have committed to the £8bn funding gap by 2020. But we all know that that then leaves £22bn of efficiency savings . . . We call on all parties to commit to a non-partisan commission . . . come up with a new settlement not just for the NHS but for social care as well."

Julia Reid: "There's been a burgeoning of management and administrators in the NHS, and we would rather have more doctors and nurses."

Health and Social Care Act and the private sector

Kailash Chand, deputy chair of the BMA, said that the policies of governments over the past two decades had increased private provision in the NHS and asked panellists how their party would ensure that the NHS was publicly funded and publicly delivered.

Hunt: "My worry about having this big debate about public versus private—as we've had in this parliament and in the last—is that you miss the real issue for patients, which is good quality care versus poor quality care."

Burnham: "If you believe in the NHS, you believe in a system based on collaboration. That's why we will repeal part three of the Health and Social Care Act and stop this drive to putting NHS services out to the market."

Lamb: "We will repeal the arrangement for the Competition and Markets Authority to have a role in the NHS; we have real concerns about the way it's been applied."

Reid [when asked whether UKIP would be with Andy Burnham in repealing the Health and Social Act]: "We would be, yes."

Mental health

Andy Bell, of the Centre for Mental Health, asked how the parties would ensure that mental health was given equal treatment to physical health and what we should expect to be different in five years.

Lamb: "We have it within our grasp of achieving genuine quality within a five year period. It is a combination of inequality of funding systems and access standards for physical health but not mental health. We've changed that with the first ever access standard for mental health from this April, but we have to make it comprehensive."

Burnham: "We've had cuts to mental health, particularly to children and adolescent mental health services. The cuts have to stop. I would give people the right to counselling and therapy."

Hunt: "Governments of all colours have underinvested in mental health over many decades. In five years' time mental health will be treated as part of integrated care, there will be more funding going in, and we need to do much more to tackle stigma around mental health."

Clash of the day

Burnham and Hunt clashed repeatedly during the debate, not least over the issue of NHS pay. Hunt refused to rule out more real terms pay cuts in the future, claiming that he had prevented thousands of nurses from being made redundant by ignoring the pay review body's recommendations of a 1% award last year. In contrast, Burnham committed to no more real terms pay cuts and pledged to reinstate the role of independent pay review bodies.

Honesty of the day

Reid, when pressed on whether UKIP's plan to bring in new county health boards would see more devolved funding to local government, said, "They would have more say in what they actually commissioned. They wouldn't be interfered with. Bearing in mind this isn't my brief."

WHO WAS THERE?

The politicians on the platform were the Conservative health secretary for England, Jeremy Hunt; Labour's shadow health secretary, Andy Burnham; the Liberal Democrat health minister Norman Lamb; and Julia Reid of the UK Independence Party (UKIP), standing in for the party's health spokesperson.

The debate was chaired by the BBC's Sarah Montague and was organised by the healthcare think tanks the Health Foundation, Nuffield Trust, and King's Fund, the NHS Confederation, the BMA, and the patients' and carers' charity National Voices. *The BMJ* was the media partner.

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Cite this as: *BMJ* 2015;350:h2165

NO HOLDS BARRED Margaret McCartney

General practice is the best job in the world

Despite political inference, wasteful awareness campaigns, misleading advertisements, poor evidence, and ridiculous media stories, general practice is still the best job in the world. GPs witness the life stories of individuals and families unfolding in real time.

Often you're a port in a storm; sometimes you offer a hand on the rudder, helping to steer the ship. You don't perform complex surgery, and the work isn't glamorous. But it is complex, requiring incisive intelligence—and, if you want glamour, you can wear whatever shoes you like.

When that patient dies, your eyes may prickle from the memory every time you go that way again. Over the years that it takes for a modest person's back-story to emerge, you get to know how extraordinary your patients are. The grit and love and devotion that people use to care about one another leave you quietly amazed.

People choose to tell you about sexual and domestic abuse before they've told anyone else. You get better at managing it, but it never becomes easy. After 10 years' infertility a couple may conceive, their joy uncontained. On the same day you may care for someone else who is dying but isn't ready. When patients you have known for years die, you feel sad and desolate yourself, and then you help the family with their grief.

There are also good deaths, and this teaches you not to fear your own. You become more comfortable with talking less, doing less, and listening more. Occasionally you get the slightly shameful thrill of making a clever diagnosis. But mostly you find pleasure in being an occasional companion to people who need that little steer and support. There is banter and fun with colleagues. And there is fun with your patients, who tease and chide and tolerate you with kindness.

General practice encompasses health and sickness, benefit and harm, living and dying. You are a prescriber, diagnostician, and font of evidence—but also an advocate and avoider of medical harm. You get things wrong sometimes, as everyone does. But you also have days when your heart sings.

Low morale and bad press are putting some young doctors off general practice, and understaffing is probably why six in 10 older doctors are considering early retirement,[1] why 17% of Scottish GP practices report at least one vacancy,[2] and why one in eight GP training places in England goes unfilled.[3]

If you want glamour, you can wear whatever shoes you like

So, to young doctors, medical students, and teenagers hesitating over university applications: come on in, bring your enthusiasm and vocation, and help us get back the job we love.

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Cite this as: *BMJ* 2015;350:h1721
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IF I RULED THE NHS John Fabre

Create a clinical chief executive role in hospitals

ELECTION 2015

The NHS remains an admirable institution but is in decline. A root cause of the malaise is the absence of a national clinical leadership structure, interestingly from its inception.

If I ruled the NHS I would begin by establishing a clinically strong NHS England board. Currently, only four of 17 board members have a medical or nursing background. I would ask nine of the medical royal colleges to put forward one nominee each and the Royal College of Nursing two nominees (excluding current members of their councils) to join as executive directors. In addition, two clinical chief executives and two chairs of regional GP boards (see below) would join.

Secondly, I would tackle the core problem of poor leadership in the hospital service by aiming to have a high calibre chief executive in each of the several hundred teaching and district general hospitals. This would be unachievable unless the minority of NHS consultants with the appropriate personal qualities took on this role. The clinical chief executive role would be for a defined period, say four years, renewable once, and the consultants would retain some clinical work (perhaps one day a week) during their tenure. They would usually return to full time clinical work. If they were given full responsibility for and discretion over all clinical and non-clinical services, and had the support of the senior staff at their hospital, this would be an interesting and potentially hugely rewarding challenge.

A root cause of the NHS's malaise is the absence of a national clinical leadership structure

The area of greatest complexity and concern is general practice, which must be a service that focuses entirely on achieving excellence in primary care. I would abolish the internal market and all commissioning (including the clinical commissioning groups themselves). General practice would be organised into regional GP boards that used existing CCG boundaries but would be run by GPs, with different responsibilities and perspectives.

The small business model for general practice should be retained. However, it must now be regulated by placing an upper limit on the number of fundable patients per GP partner in a practice, to encourage practices to become sensibly staffed and partner based. This regulation would be put in place after a transition phase of three years, during which 4000 centrally funded young GPs would be distributed by the regional GP boards to general practices at no cost to the practice, so as to reduce each GP's workload without loss of income. At the end of the transition phase I would ask GPs to negotiate a resumption of a GP implemented out-of-hours service, either nationally or at GP board level.

I would also consider alternative approaches to the monitoring of quality of care, and in the interim I suggest that all doctors and nurses read the executive summary of Robert Francis QC's report into failings in care at Mid Staffordshire NHS Foundation Trust (http://bit.ly/1ELjQ7D).

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Cite this as: *BMJ* 2015;350:h2041

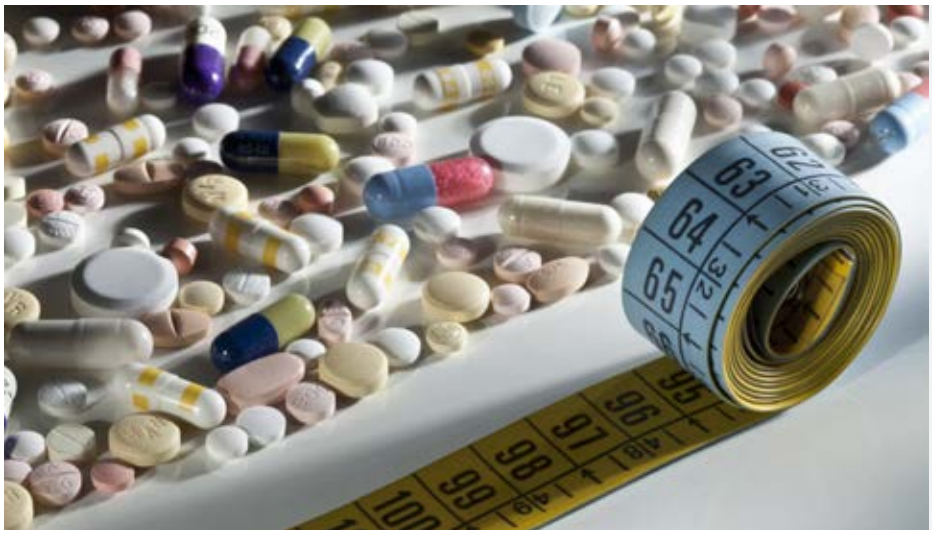
We need a drug formulary for obese people

Drugs are licensed in doses for patients of ideal weight, writes **Stephen Head**, and doctors need guidance on their effective and safe use in others

We have an obesity epidemic, with many people weighing well above what was considered when drugs were trialled. These patients may not receive the best care possible when it comes to drug treatment.

Recommended "adult doses" of drugs need to be effective and safe for slender, shorter than average people who might weigh, say, less than 45 kg. But is a dose range that is effective and safe for a 45 kg person also effective and safe for someone three times that weight?

We often impose restrictions on specific interventions in morbidly obese patients: for example, people with a body mass index greater than 40 may be advised to lose weight before joint replacement surgery, owing to increased risk and worse outcomes. But to what extent are these increased risks and worse outcomes the result of inadequate dosing—whether in perioperative care, management of complications, or rehabilitation?



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When prescribing for children we do not simply assume that they are smaller adults; similarly, obese people are not simply bigger adults. Differences in pharmacodynamics mean that guessing the best dose will not suffice

Uncertainty and guesswork

How should we decide the optimum drug doses for morbidly obese people? With many drugs this is uncertain, and we use guesswork. Or we simply prescribe as though the patient weighed 45 kg, because increasingly risk averse doctors are more reluctant to prescribe a dose outside the recommended range.

For some drugs we might infer a suitable dose. An example is beta blockers, where resting pulse rate is a reliable surrogate marker for adequate dosing. For other drugs, such as levothyroxine, blood test monitoring helps us to get the dose right.

Hypertension is a common problem among obese people. Titration to target is standard but can lead to dangerous polypharmacy if, at the maximum recommended dose, plasma concentrations are beneath the therapeutic threshold for effectiveness.

Suboptimal plasma concentrations may also cause therapeutic failure with antibacterials. A second drug may be tried, when the first would have worked with the right dose. If initial therapy fails the patient might require hospital admission, at great personal and financial cost. Some antibacterials have a narrow therapeutic window that can be missed without monitoring, although this problem is less likely with some, such as beta lactams. Inappropriate prescribing also has implications for antibiotic resistance because inadequate plasma concentrations can promote the selective growth of resistant strains.[1]

Diabetes is common in morbidly obese people, and current dosing regimens may be insufficient. How many patients might achieve acceptable glycaemic control with metformin monotherapy if they took bigger doses than those currently licensed?

Symptomatic musculoskeletal conditions are almost inevitable in obese people. Apart from the ethical imperative to relieve symptoms, giving an insufficient dose may inadequately control symptoms and limit physical activity, promoting a vicious cycle with further weight gain or a failure to lose weight.

"Pharmacobariatrics" won't come cheap, as new trials are needed to investigate how dosing should reflect body weight. Investment may be contentious, especially among those who regard obesity as a self induced condition for which they have little sympathy. And it might attract the drug industry, although most of the drugs that matter are off patent, with limited potential for gain in income.

The NHS and the government should support this work because it could promote health and reduce complications and costs. The costs of obesity are huge, and anything to mitigate them should be welcomed.

Differences in pharmacodynamics

When prescribing for children we do not simply assume that they are smaller adults; similarly, obese people are not simply bigger adults. Differences in pharmacodynamics—such as absorption, distribution (lipophilic drugs may be a particular concern), metabolism (what about fatty liver?), and excretion—mean that guessing the best dose will not suffice.[2 3]

By using preferred treatments in effective doses treatment failures will be fewer, lessening the need for add-on or alternative treatments. These extra treatments are often newer and more expensive, with fewer long term safety data.

A huge research agenda in pharmacobariatrics would lead to better clinical practice and would benefit obese patients, the health economy, and wider society. In the United Kingdom we have a *British National Formulary* and a *British National Formulary for Children*; we also need a *British National Formulary* for obese people.

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References are in the version on thebmj.com.

Cite this as: *BMJ* 2015;350:h1356